

No. 83-2136-CFX
Status: GRANTED

Title: Connecticut, Department of Income Maintenance,
Petitioner

V.
Margaret M. Heckler, Secretary, Department of Health
and Human Services, et al.

Docketed:
June 28, 1984

Court: United States Court of Appeals
for the Second Circuit

Counsel for petitioner: Miller, Charles A.

Counsel for respondent: Solicitor General

Entry	Date	Note	Proceedings and Orders
1	Jun 28 1984	G	Petition for writ of certiorari filed.
3	Jul 23 1984		Order extending time to file response to petition until August 27, 1984.
4	Aug 10 1984		Order further extending time to file response to petition until September 26, 1984.
5	Sep 28 1984		Brief of respondents Heckler, Sec. of H&HS, et al. in opposition filed.
6	Oct 3 1984		DISTRIBUTED. October 26, 1984
7	Oct 22 1984	X	Reply brief of petitioner CT, Dept. of Income Maint. filed.
8	Oct 29 1984		Petition GRANTED. *****
10	Nov 30 1984		Order extending time to file brief of petitioner on the merits until January 2, 1985.
12	Nov 30 1984		Order extending time to file brief of respondent on the merits until February 19, 1985.
13	Jan 2 1985		Brief amicus curiae of American Psychiatric Assn., et al. filed.
14	Jan 2 1985		Brief of petitioner CT, Dept. of Income Maintenance filed.
15	Jan 2 1985		Brief amicus curiae of Illinois, et al. filed.
16	Jan 2 1985		Brief amicus curiae of Massachusetts filed.
17	Jan 11 1985		Application of petitioner's to file brief on the merits in excess of the page limitation, and order granting same by Marshall, J., on January 14, 1985. (A-536) The brief may not exceed 120 pages.
18	Jan 11 1985		
19	Jan 24 1985		Joint appendix filed.
20	Jan 28 1985		Record filed.
21	Feb 5 1985		SET FOR ARGUMENT. Wednesday, March 27, 1985. (2nd case).
22	Feb 19 1985		Brief of respondents Heckler, Sec. of H&HS, et al. filed.
23	Mar 5 1985		CIRCULATED.
24	Mar 6 1985	X	Reply brief of petitioner CT, Dept. of Income Maintenance, filed.
25	Mar 27 1985		ARGUED.

83-2136 (1)

Office - Supreme Court, U.S.
FILED
JUN 28 1984
ALEXANDER L. STEVAS.
CLERK

IN THE
Supreme Court of the United States

October Term, 1983

No. 84-

STATE OF CONNECTICUT, DEPARTMENT OF
INCOME MAINTENANCE,

Petitioner,

v.

MARGARET M. HECKLER, SECRETARY, AND THE UNITED STATES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Respondents.

**PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT**

DONALD M. LONGLEY
Assistant Attorney General
90 Brainard Road
Hartford, Connecticut 06114

CHARLES A. MILLER*
MICHAEL A. ROTH
Covington & Burling
1201 Pennsylvania Avenue,
N.W.
P.O. Box 7566
Washington, D.C. 20044
(202) 662-6000

*Attorneys for Petitioner
State of Connecticut,
Department of Income
Maintenance*

*Counsel of Record

June 1984

169.00

QUESTION PRESENTED

Whether a limitation in the Medicaid law on use of federal funds to reimburse states for the care of patients in "institutions for mental diseases" should be confined to traditional mental hospitals or should be extended to cover newly developed "intermediate care facilities" that serve residents with mental conditions calling for a lesser level of custodial care.

TABLE OF CONTENTS

	<u>Page</u>
OPINIONS BELOW	1
JURISDICTION	2
STATUTORY PROVISIONS INVOLVED	2
STATEMENT	3
REASONS FOR GRANTING THE WRIT	7
A. Federal Courts Are In Conflict On The Important Issue Of The Scope Of The IMD Provision Of The Medicaid Law	7
B. The Decision Below Conflicts With This Court's Prior Readings Of The IMD Provision	9
C. The Scope Of Medicaid Coverage For Needy Mentally Ill People Under Age 65 Is An Important And Recurring Issue	11
CONCLUSION	13
APPENDIX A (Opinion of the Court of Appeals for the Second Circuit)	1a
APPENDIX B (Judgment of the Court of Appeals for the Second Circuit)	1b
APPENDIX C (Opinion of the United States District Court for the District of Connecticut)	1c
APPENDIX D (Opinion of the Departmental Grant Appeals Board of the United States Department of Health and Human Services)	1d
APPENDIX E (Opinion of the Court of Appeals for the Eighth Circuit)	1e
APPENDIX F (Opinion of the United States District Court for the Northern District of Illinois)	1f

TABLE OF AUTHORITIES

	<u>Page</u>
CASES:	
<i>Doe v. Colautti</i> , 592 F.2d 704 (3d Cir. 1979)	10
<i>Illinois v. United States Department of Health and Human Services</i> , No. 82-C-1349 (N.D. Ill. March 20, 1984)	4,8,9
<i>Kantrowitz v. Weinberger</i> , 388 F. Supp. 1127 (D.D.C. 1974), <i>aff'd</i> , 530 F.2d 1034 (D.C. Cir.), <i>cert. denied</i> , 429 U.S. 819 (1976)	10
<i>Legion v. Richardson</i> , 354 F. Supp. 456 (S.D.N.Y.), <i>aff'd sub nom. Legion v. Weinberger</i> , 414 U.S. 1058 (1973)	10
<i>Massachusetts v. Heckler</i> , No. 83-2239-MC (D.Mass. filed August 1, 1983)	11
<i>Minnesota v. Heckler</i> , 718 F.2d 852 (8th Cir. 1983) ...	4,8,9
<i>Minnesota v. Schweiker</i> , No. 4-82-155 (D.Minn. August 25, 1982)	4
<i>Schweiker v. Wilson</i> , 450 U.S. 221 (1981)	10,11
FEDERAL STATUTES AND REGULATIONS:	
Social Security Act, Title XIX (Grants to States for Medical Assistance Programs):	
42 U.S.C. § 1396a(a)(20)	5,7
42 U.S.C. § 1396a(a)(21)	5,7
42 U.S.C. § 1396d(a)(1)	2
42 U.S.C. § 1396d(a)(4)(A)	2
42 U.S.C. § 1396d(a)(14)	2
42 U.S.C. § 1396d(a)(15)	2,5
42 U.S.C. § 1396d(a)(18)(B)	3,5
42 U.S.C. § 1396d(c)	3,5
42 C.F.R. § 435.1009(e)	6
MISCELLANEOUS:	
S. Rep. No. 404, Pt. I, 89th Cong., 1st Sess. (1965)	5,10
Social Security Amendments of 1971: Hearings on H.R. 1 before the Senate Committee on Finance, Pt. 2, 92d Cong., 1st & 2d Sess. (1972)	9

IN THE
Supreme Court of the United States

October Term, 1983

No. 84-

STATE OF CONNECTICUT, DEPARTMENT OF
INCOME MAINTENANCE,

Petitioner,

v.

MARGARET M. HECKLER, SECRETARY, AND THE UNITED STATES
DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Respondents.

**PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT**

Petitioner ("Connecticut") petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Second Circuit in this case.

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Second Circuit is reported at 731 F.2d 1052 and appears as Appendix A, pp. 1a-16a. The opinion of the United States District Court for the District of Connecticut is reported at 557 F. Supp. 1077 and appears as Appendix C, pp. 1c-25c. The opinion of the Departmental Grant Appeals Board of the United States Department of Health and Human Services ("DHHS") is unreported and appears as Appendix D, pp. 1d-61d.

JURISDICTION

The judgment of the Court of Appeals was entered on March 30, 1984. App. B, p. 1b. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

The following are provisions of the Social Security Act, Title XIX (Grants to States for Medical Assistance Programs), Pub. L. No. 89-97, § 121, 79 Stat. 343-353 (1965) (as amended):

1. Section 1905(a) of the Act, 42 U.S.C. § 1396d(a)(1), (4)(A), (14), (15) and (18)(B), as amended, provides in relevant part:

“(a) The term ‘medical assistance’ means payment of part or all of the cost of the following care and services . . .

(1) inpatient hospital services (other than services in an institution for tuberculosis or mental diseases);

• • •

(4)(A) skilled nursing facility services (other than services in an institution for tuberculosis or mental diseases) for individuals 21 years of age or older; . . .

• • •

(14) inpatient hospital services, skilled nursing facility services, and intermediate care facility services for individuals 65 years of age or over in an institution for tuberculosis or mental diseases;

(15) intermediate care facility services (other than such services in an institution for tuberculosis or mental diseases) for individuals who are determined . . . to be in need of such care;

• • •

(18) . . . ; except as otherwise provided in paragraph (16), such term does not include . . . (B) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for tuberculosis or mental diseases.”

2. Section 1905(c) of the Act, 42 U.S.C. § 1396d(c), as amended, provides in relevant part:

“(c) For purposes of this subchapter the term ‘intermediate care facility’ means an institution which (1) is licensed under State law to provide, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities The term ‘intermediate care facility’ also includes any skilled nursing facility or hospital which meets the requirements of the preceding sentence With respect to services furnished to individuals under age 65, the term ‘intermediate care facility’ shall not include, except as provided in subsection (d) of this section, any public institution or distinct part thereof for mental diseases or mental defects.”

The provisions with respect to intermediate care facilities were added by section 4(a) of the Social Security Amendments of 1971, Pub. L. No. 92-223, 85 Stat. 809.

STATEMENT

This case presents an important and recurring question of interpretation of the statute establishing the Medicaid program that has been decided against DHHS by four federal courts, but was decided in favor of DHHS by the court below. That

decision is in square conflict with the decision of the Court of Appeals for the Eighth Circuit in *Minnesota v. Heckler*, 718 F.2d 852 (1983) (Appendix E hereto).

The question is what Congress meant in using the term "institution for mental diseases" in defining the kinds of health-related services covered by the Medicaid program. The dispute turns on whether this term was meant to cover only facilities providing the level and intensity of care that is characteristic of mental hospitals, as held by the Eighth Circuit court, or, as the Second Circuit court held, embraces as well intermediate care facilities ("ICFs"), which provide a much less intensive level of care and have been developed to treat persons with mental conditions but for whom the level of care provided by mental hospitals is inappropriate and unnecessary.

The case arises as a result of actions taken by an agency of DHHS to "disallow" federal funding for services provided to residents in certain ICFs in the States of Connecticut, Minnesota and Illinois, and certain skilled nursing facilities ("SNFs") in California. The disallowances were upheld in a single consolidated decision by the Departmental Grant Appeals Board, a body within DHHS established by the Secretary to resolve disallowance disputes. The Board's decision was appealed separately by each of the affected states. The Minnesota disallowance was set aside by the District Court for the District of Minnesota¹ and that decision was upheld by the Eighth Circuit Court of Appeals (Appendix E). The Illinois disallowance was set aside by the District Court for the Northern District of Illinois in *Illinois v. United States Department of Health and Human Services*, No. 82-C-1349 (March 20, 1984) (Appendix F). The Connecticut disallowance was also set aside by the District Court for the District of Connecticut (557 F. Supp. 1077) (Appendix C). However, that decision was reversed and the disallowance reinstated by the court below.²

¹ *Minnesota v. Schweiker*, No. 4-82-155 (D. Minn. August 25, 1982).

² No decision has yet been rendered in the suit brought by California to challenge the Grant Appeals Board decision.

The origins of the Connecticut dispute and the history of the litigation below can be summarized as follows:

The Medicaid program, established in 1965, makes federal funds available to the states to share in the costs of medical care provided to needy eligible individuals, to the extent covered by an approved State Plan. The original statute excluded from federal financial participation services provided to patients under age 65 in institutions for mental diseases ("IMDs"). 42 U.S.C. § 1396d(a)(18)(B). It permitted coverage for institutional services for persons 65 and over in IMDs only on the condition that the state undertake programs to develop broader options for dealing with the problems of the mentally ill, including use of nursing facilities and other less intensive alternatives to IMDs. 42 U.S.C. § 1396a(a)(70) and (21); S. Rep. No. 404, Pt. I, 89th Cong., 1st Sess. 145-46 (1965). The term IMD was not defined in the statute.

In 1971, Congress brought ICF services under the coverage of the Medicaid program. 42 U.S.C. § 1396d(a)(15). An ICF was defined as an institution that provides medical assistance to individuals who because of their mental or physical condition require health care and services, but who do not require the degree of care and treatment that a hospital or skilled nursing facility provide. 42 U.S.C. § 1396d(c).

Since October 1974, Connecticut has included intermediate care facility services in its State Medicaid Plan. *Jt. App.* 55-56.³ The facility in question in this case, Middletown Haven Rest Home, is an ICF that began operating as a duly certified Medicaid provider in 1977.⁴ Connecticut received federal funds under the Medicaid program for services provided to eligible residents of Middletown Haven from 1977 through 1980. *App. A*, p. 4a.

³ "Jt. App." refers to the Joint Appendix containing the record before the Court of Appeals.

⁴ Connecticut has a number of public mental hospitals and private psychiatric hospitals that are concededly IMDs. *Jt. App.* 53-54.

In December 1979, an audit conducted by DHHS found that most of the residents of Middletown Haven had mental diagnoses and concluded that Middletown Haven should be classified as an IMD, and, therefore precluded from federal sharing in the cost of any services rendered to residents at the facility. The audit conclusions were based on criteria that looked only to the diagnoses of the residents of the facility under review, and not to the nature of the care provided to the residents, in determining whether the facility was an IMD. *Jt. App.* 12-21.⁵

In September 1980, Connecticut received a notice of disallowance in the amount of \$1,634,655, which represented federal financial participation payments that previously had been made to Connecticut for services provided to residents of Middletown Haven during the period 1977 through 1979.⁶ Connecticut sought administrative review of the disallowance before the Grant Appeals Board. This action was consolidated with similar disallowances affecting three other states. The Board's decision upholding the disallowances led to the judicial proceedings summarized above, including the decision of the Court of Appeals for the Second Circuit reversing the District Court and upholding the disallowance.

Jurisdiction of the courts below was conferred by 28 U.S.C. § 1331 based on a right of action provided by the Administrative Procedure Act, 5 U.S.C. § 704. Both courts found that the District Court possessed jurisdiction. *App. A*, p. 7a; *App. C*, pp. 2c-3c.

⁵ The criteria were never formally published but were set forth in instructions issued to field staff. *See App. D*, pp. 26d-28d. The only published material is a regulation providing that whether a facility is an IMD depends on "its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases." 42 C.F.R. § 435.1009(e).

⁶ The disallowance was not predicated in any way on the quality of service provided at Middletown Haven. The responsible DHHS official described Middletown Haven as an "excellent facility" and an "ideal ICF." *Jt. App.* 76.

REASONS FOR GRANTING THE WRIT

Certiorari is warranted because the decision below squarely conflicts with the decision of another Court of Appeals reviewing the same administrative action, because the decision rests on a construction of the term "institution for mental diseases" as used in the Medicaid law that is inconsistent with this Court's prior expressed understanding of the provision, and because of the general importance and recurring nature of the issue presented. Resolution of the conflict over the meaning of the statutory term will determine the scope of Medicaid coverage of services developed to meet the Congressional objective, which was the creation of new kinds of facilities for people suffering some mental illness but who do not need the costly and intensive care provided by IMDs.⁷

A. Federal Courts Are In Conflict On The Important Issue Of The Scope Of The IMD Provision Of The Medicaid Law.

The major issue addressed by the Grant Appeals Board and in the judicial review actions brought by the affected states was whether the limitation on Medicaid coverage for services in IMDs extends to nursing and intermediate care facilities. Because of DHHS' view that any custodial facility participating in the Medicaid program could be an IMD, DHHS criteria for applying the IMD proviso did not consider the nature of the services provided by the facility. Thus, in applying the IMD provision, DHHS drew no distinction between mental hospitals and facilities providing lower levels of care, notwithstanding the extension of the Medicaid program in 1971 to ICFs, defined in the statute as facilities for persons requiring care because of their mental (or physical) condition.

⁷ *See* Section 1902(a)(20) and (21) of the Social Security Act, 42 U.S.C. § 1396a(a)(20) and (21), enacted as part of the original Medicaid law in 1965, Pub. L. No. 89-97, § 121, 79 Stat. 347 (1965).

The Court of Appeals for the Eighth Circuit, relying upon the language and legislative history of the statute, rejected DHHS' views that the definition of IMD turned essentially on the diagnosis of the residents and that there was no distinction between mental hospitals and ICFs for IMD purposes. The court found the meaning of the term IMD to turn on the nature of the services rendered by the facility, and distinguished between the level of care required for patients in IMDs and the level of care offered in ICFs. App. E, pp. 17e-18e, 22e-23e.

A similar interpretation of the statute was adopted by the District Court in the Illinois case (App. F, p. 3f) and by the District Court in this case (App. C, pp. 20c-21c). However, the Second Circuit Court of Appeals expressly rejected the analysis of the Eighth Circuit court (App. A, p. 6a n.4) and instead accepted DHHS' view of the statutory term.

The Second Circuit court's holding in this case stems from a misunderstanding of the statute and its legislative history. The court acknowledged that there was logic to the State's construction of the statute, particularly its reliance on the extension of Medicaid to ICFs, which were created to serve people whose mental or physical condition required custodial care, albeit of a less intensive nature than is characteristic of mental institutions. The court's election of the DHHS view as "more plausible" was based on an incorrect notion, not advanced below by DHHS, that the State's view would arbitrarily distinguish between free-standing ICFs and those that were part of a mental hospital. App. A, pp. 8a-9a.⁸ Each of the other federal courts analyzed the words of the Medicaid law and reached a conclusion opposite to that of the court below on the meaning of the IMD limitation.

⁸ The court's decision leads to the truly arbitrary result that Medicaid coverage is available for some ICFs that care for people with mental conditions but not others, depending on whether the ICF is classified as an IMD under the agency's subjective criteria.

Likewise, the court below erred in its legislative history analysis by relying on certain statements at Congressional hearings by witnesses who were seeking outright elimination of the IMD provision (App. A, pp. 12a-14a),⁹ while ignoring all of the extensive legislative history showing that the IMD provision, when first enacted and later, was consistently recognized by all, including the most involved members of Congress, as encompassing only mental hospitals. Here again, the analysis of the Second Circuit court is directly at odds with the view of the legislative history taken by the District Court and by the courts in the Minnesota and Illinois cases.¹⁰ See App. C, pp. 9c-20c; App. E, pp. 18e-23e; App. F, p. 2f.

While fuller argument would confirm the error of the Second Circuit court's analysis, it suffices now to show that both that court and the Eighth Circuit court addressed the same question of statutory interpretation and reached opposite results upon consideration of the statutory provisions and the legislative history. Only a decision by this Court can resolve the conflict in interpretation of this important provision of the Medicaid law.

B. The Decision Below Conflicts With This Court's Prior Readings Of The IMD Provision.

In its submissions to the courts below, Connecticut showed that the statutory term "institution for mental diseases" was intended to encompass only mental hospitals, not alternatives like ICFs that offered a lower level of care. That understanding

⁹ The excerpts relied on by the court were never cited or relied upon either by the Grant Appeals Board or by DHHS in any of the briefs filed in the courts below.

¹⁰ The court below misconstrued the hearing excerpts on which it did rely. The principal testimony cited by the court came from spokesmen for the National Association of State Mental Health Program Directors. The January 1972 statement on behalf of that organization recognized not only that the IMD exclusion was confined to mental hospitals, but that the ICF provisions added to the Medicaid statute in December 1971 provided an alternative in the Medicaid program for care of the mentally ill. See Social Security Amendments of 1971: Hearings on H.R. 1 Before the Senate Committee on Finance, Pt. 2, 92d Cong., 1st & 2d Sess. 940 (1972).

of the intent of Congress is reflected in this Court's decision in *Schweiker v. Wilson*, 450 U.S. 221 (1981). There the Court was considering a provision of the Supplemental Security Income program (Title XVI of the Social Security Act) that was affected by the IMD exclusion in the Medicaid program.¹¹ Both the majority and dissenting opinions characterized the IMD exclusion as applying to mental hospitals. The opinion for the Court, relying on the legislative history of the 1965 Act, stated that the IMD provision was adopted because "long-term care in such *hospitals* had traditionally been accepted as a responsibility of the States." *Id.* at 237 n.19, quoting from S. Rep. No. 404, Pt. I, 89th Cong., 1st Sess. 144 (1965) (emphasis supplied). Mr. Justice Powell's dissenting opinion on behalf of four Justices went further and explained the rationale of the IMD exclusion as follows:

"The residual exclusion of large state institutions for the mentally ill from federal financial assistance rests on two related principles: States traditionally have assumed the burdens of administering this form of care, and the Federal Government has long distrusted the economic and therapeutic efficiency of large mental institutions." *Id.* at 242 (citing the 1965 Senate Report).¹²

¹¹ The question in that case was whether the payment of subsistence allowances to certain Supplemental Security Income recipients residing in institutions, but not to those aged 21 through 64 in IMDs, created a constitutionally impermissible classification.

¹² Other courts that have considered the IMD exclusion also have characterized it only in terms of mental hospitals, based on a reading of the legislative history. See, e.g., *Doe v. Colautti*, 592 F.2d 704, 709 (3d Cir. 1979) (referring to exclusion as relating to "inpatient care at a psychiatric hospital"); *Kantrowitz v. Weinberger*, 388 F. Supp. 1127, 1130 (D.D.C. 1974), *aff'd*, 530 F.2d 1034 (D.C. Cir.), *cert. denied*, 429 U.S. 819 (1976) (describing exclusion as relating to payments for inpatient care in mental hospitals); *Legion v. Richardson*, 354 F. Supp. 456, 459 (S.D.N.Y.), *aff'd sub nom. Legion v. Weinberger*, 414 U.S. 1058 (1973) (noting Congress' belief that care of the mentally ill "in state hospitals" was the responsibility of the states). The latter two decisions were cited with approval by the Court in *Schweiker v. Wilson*, *supra*, at 237 n.19.

Connecticut relied on the *Schweiker* case in its briefs below to support its argument that the term IMD was meant to cover only mental hospitals and did not embrace ICFs. But the court below did not refer to the *Schweiker* case, and the court's analysis of the IMD provision is inconsistent with the understanding of that provision on which the opinions in the *Schweiker* case were premised.

C. The Scope Of Medicaid Coverage For Needy Mentally Ill People Under Age 65 Is An Important And Recurring Issue.

The question whether the limitation on Medicaid coverage for services in IMDs extends to ICFs and other less intensive forms of care for persons whose mental condition requires treatment is an important one that will affect states throughout the country, all of which participate in the Medicaid program and provide ICF services for the mentally ill. The Grant Appeals Board decision was the first of its kind, but already other states have been confronted with similar disallowances.¹³ Tens of millions of dollars in federal funds have been granted to the states to reimburse the costs of ICF services to persons with mental conditions. The decision below puts many of those grants in jeopardy of after-the-fact disallowance, and thus poses a major new fiscal problem for hard-pressed state governments.¹⁴

Moreover, unless the conflict between the circuit courts is resolved, certain states will be denied federal Medicaid funding for identical ICF services that are supported by federal Medicaid funding in other states. The need for consistent application of the Medicaid statute among the states of the union is manifest. Here, the problem is particularly acute because of the

¹³ For example, a Massachusetts disallowance has been upheld by the Grant Appeals Board, and the state has initiated an action seeking judicial review. *Massachusetts v. Heckler*, No. 83-2239-MC (D. Mass., filed August 1, 1983). Another disallowance involving Colorado is pending before the Grant Appeals Board.

¹⁴ There is no time limitation in the statute or regulations on federal audit and disallowance of federal funding previously provided to states in the Medicaid program.

recurring nature of the issue on which the courts have reached conflicting decisions. States throughout the country continue to provide services to mentally ill people in ICFs who meet the eligibility requirements for Medicaid. The states are subject to recoupment of the federal share of the cost of these services if the ICFs are later found to be IMDs. Thus, the question of the meaning of the IMD exclusion continues to be a matter of great moment, and needs to be definitively resolved.

Beyond this, the question raised in this case goes directly to the type of health care available to needy people. At stake is whether, as envisioned by Congress, less fortunate people of our nation who suffer from mental conditions requiring treatment can have access to less intensified (and less expensive) settings—such as ICFs—under the Medicaid law. Since Congress clearly intended use of the Medicaid program to encourage the development of such alternatives to IMDs for dealing with the problems of the mentally ill,¹⁵ the actions of DHHS prohibiting Medicaid coverage for ICFs primarily devoted to residents with mental conditions are in direct conflict with the Congressional intent.

In sum, the question of the scope of the IMD exclusion under Medicaid law calls for definitive resolution. This issue represents “an important question of federal law which has not been, but should be, settled by this court” Sup. Ct. R. 17.1(c).

¹⁵ The court below acknowledged this Congressional policy, but erroneously read it as applying only to care for the elderly (App. A, pp. 11a-12a), a limitation not included in the statute. See note 7, p. 7, *supra*.

CONCLUSION

For the reasons stated, the writ of certiorari should be issued.

Respectfully submitted,

DONALD M. LONGLEY
Assistant Attorney General
90 Brainard Road
Hartford, Connecticut 06114

CHARLES A. MILLER*
MICHAEL A. ROTH
Covington & Burling
1201 Pennsylvania Avenue,
N.W.
P.O. Box 7566
Washington, D.C. 20044
(202) 662-6000

*Attorneys for Petitioner State
of Connecticut, Department of
Income Maintenance*

*Counsel of Record

June 1984

APPENDIX A

United States Court of Appeals

FOR THE SECOND CIRCUIT

No. 245—August Term, 1983

(Argued September 26, 1983 Decided March 30, 1984)

Docket No. 83-6105

STATE OF CONNECTICUT, DEPARTMENT OF
INCOME MAINTENANCE,

Plaintiff-Appellee,

v.

MARGARET M. HECKLER, SECRETARY, and the UNITED
STATES DEPARTMENT OF HEALTH and HUMAN SERVICES,
Defendants-Appellants.

Before:

MANSFIELD, KEARSE and WINTER,

Circuit Judges.

Appeal from an order of the United States District Court for the District of Connecticut (M. Joseph Blumenfeld, *Judge*), reversing a decision by the United States Department of Health and Human Services which disallowed federal Medicaid payments to the State of Connecticut for services provided to patients at Middletown Haven Rest Home.

Reversed.

CHARLES A. MILLER, Washington, D.C. (Joan E. Donoghue, Covington & Burling, Washington, D.C., Joseph I. Lieberman, Attorney General, State of Connecticut, Edmund Walsh, Assistant Attorney General, State of Connecticut, on the brief), *for Plaintiff-Appellee.*

SUSANNE M. LEE, Washington, D.C. (Juan A. del Real, Ann T. Hunsaker, Department of Health and Human Services, Washington, D.C., on the brief), for *Defendants-Appellants*.

WINTER, *Circuit Judge*:

The United States Department of Health and Human Services ("HHS") appeals from Judge Blumenfeld's decision that HHS improperly disallowed Medicaid payments to the State of Connecticut Department of Income Maintenance ("Connecticut") for services provided patients at Middletown Haven Rest Home ("Middletown Haven"). Judge Blumenfeld held that the statutory provisions relied on by HHS only preclude Medicaid payments for services rendered at "mental hospitals," which are "facilities which . . . provide total care to mental patients." *Connecticut v. Schweiker*, 557 F.Supp. 1077, 1090-91 (D. Conn. 1983). Because Middletown Haven, a duly certified intermediate-care facility ("ICF"), does not provide total care to such patients, Judge Blumenfeld concluded that HHS wrongfully had disallowed Medicaid payments for services provided there.

We reverse.

BACKGROUND

This case arises under the Medicaid legislation, Title XIX of the Social Security Act, enacted as part of the Social Security Amendments of 1965, Pub. L. No. 89-97, § 121, 79 Stat. 286, 343-52 (codified as amended at 42 U.S.C. § 1396 *et seq.*). Congress established Medicaid "for the purpose of providing federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons." *Harris v. McRae*, 448 U.S. 297, 301 (1980). Medicaid provides federal financial assistance for certain categories of medical treatment, including "inpatient hospital services (other than services in an institution for . . . mental diseases)," 42 U.S.C. § 1396d(a)(1), "skilled nursing facility services (other than services in an

institution for . . . mental diseases)," *id.* at § 1396d(a)(4A), and "intermediate care facility services (other than such services in an institution for . . . mental diseases)," *id.* at § 1396d(a)(15). This assistance is also subject to two blanket provisions, one forbidding federal financial assistance "with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for . . . mental diseases," *id.* at § 1396d(a)(18)(B), and the other authorizing federal financial assistance for "inpatient hospital services, skilled nursing facility services, and intermediate care facility services for individuals 65 years of age or over in an institution for . . . mental diseases," *id.* § 1396d(a)(14).

The statute defines ICF's as

licensed under State law to provide, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities.

Id. § 1396d(c). The term "institution for mental diseases" ("IMD") is not defined in the statute but has been interpreted by HHS to mean any institution "primarily engaged in providing diagnosis, treatment or care of persons with mental diseases." 42 C.F.R. § 435.1009. The parties agree that the dispositive issue in the instant case is whether an ICF such as Middletown Haven can be deemed an IMD, given the foregoing statutory and regulatory framework.

Because the statutory provisions at issue here were enacted in a piecemeal fashion, the sequence as well as the substance of the various parts of the statutory scheme is significant. The original Medicaid statute authorized federal financial assistance for inpatient hospital services and skilled nursing facility services except when rendered in an IMD, Pub. L. No. 89-97, § 121(a), 79 Stat. 286, 351 (1965) (codified as amended at 42 U.S.C. § 1396d(a)(1), (4)(A)). The original statute also

contained the blanket provisions authorizing financial assistance for those services to patients 65 or older in IMD's, *id.*, 79 Stat. at 352 (codified as amended at 42 U.S.C. § 1396d(a)(14)), but precluding it for those services to patients under age 65 in an IMD, *id.* (codified as amended at 42 U.S.C. § 1396d(a)(18)(B)). The original Medicaid statute made no provision for financial assistance for ICF services.

In 1967, Congress authorized federal assistance for ICF services under special programs for the aged, the blind and the disabled. Social Security Amendments of 1967, Pub. L. No. 90-248, § 250, 81 Stat. 821, 920 (repealed 1971). ICF coverage to those eligible under the Medicaid program was authorized in 1971, Pub. L. No. 92-223, § 4, 85 Stat. 802, 809 (1971), when Congress repealed the 1967 legislation and brought ICF coverage under the Medicaid program. However, in doing so, Congress expressly excluded ICF services rendered in an IMD.¹ *Id.* § 4(a)(1)(C), 85 Stat. 802, 809 (codified as amended at 42 U.S.C. § 1396d(a)(15)). The ICF definition adopted in the 1971 Medicaid legislation, which is quoted *supra*, resembled that used in the 1967 legislation, except that the 1971 definition explicitly stated that "the term 'intermediate care facility' shall not include . . . any public institution or distinct part thereof for mental diseases or mental defects." *Id.* § 4(a)(2) (codified at 42 U.S.C. § 1396d(c)). An exception to this general exclusion was made for public institutions treating the mentally retarded. *Id.* (codified at 42 U.S.C. § 1396d(d)). The 1971 definition is the one at issue in the instant case.

From the time that Middletown Haven began operation as an ICF in 1977, Connecticut received federal Medicaid funds to help defray the costs of services provided patients at the facility. The legality of this arrangement came under scrutiny in December 1979, when an audit team from HHS undertook a study of

¹ By oversight, the 1971 legislation did not explicitly declare that the IMD exclusion did not prevent the use of Medicaid funds to reimburse states for ICF services provided the elderly in IMDs. A technical amendment was passed in 1972 to clarify this point. Social Security Amendments of 1972, Pub. L. No. 92-603, § 297(a), 86 Stat. 1329, 1459-60 (codified at 42 U.S.C. § 1396d(a)(14)); see S. Rep. No. 1230, 92d Cong., 2d Sess. 320-21 (1972).

patient records at Middletown Haven. The study was conducted as part of an investigation by HHS to determine whether certain states were discharging patients from mental hospitals and arranging their placement in ICF's in order to circumvent the Medicaid exclusion for patients under age 65 in IMD's. Applying internal criteria developed by HHS and intended to supplement the IMD definition set forth in the regulations,² the audit team concluded that Middletown Haven was an IMD. In drawing this conclusion, it found, *inter alia*, that 77% of the patients treated from January, 1977 through December, 1979 were suffering from a major mental disease that was responsible in substantial part for their need of ongoing care, that more than 50% of the patients had been admitted directly from state mental hospitals, and that Middletown Haven hired professional staff, including three psychiatrists, who specialized in the care of the mentally ill. Following the audit team's report, HHS disallowed all Medicaid payments made for services provided patients at Middletown Haven between January, 1977 and September, 1979—an amount totalling \$1,634,655.³

² The HHS criteria instruct audit teams to focus on the following characteristics of the institution at issue:

1. Licensed as a mental institution.
2. Advertised as a mental institution.
3. More than 50% of the patients have a disability in mental functioning.
4. Used by mental hospitals for alternative care.
5. Patients who may have entered mental hospitals are accepted directly from the community.
6. Proximity to State mental institutions (within a 25 mile radius).
7. Age distribution uncharacteristic of nursing home patients.
8. Basis of Medicaid eligibility for patients under 65 is due to mental disability.
9. Hires staff specialized in the care of the mentally ill.
10. Independent professional reviews conducted by state teams report a preponderance of mental illness among patients in the facility.

³ Of the amount disallowed by HHS, \$1,137,138 was for services provided patients between the ages of 21 and 65, and \$497,517 for services provided patients in other age groups. Under the Medicaid statute, states have the option to choose whether they wish to receive federal financial assistance for services provided patients over age 65 in IMD's. See 42 U.S.C.

Connecticut then sought agency review of the disallowance. Its appeal, consolidated with appeals from similar disallowances by the states of Minnesota, Illinois and California, was heard before the Departmental Grant Appeals Board of HHS. On November 30, 1981, the appeals were denied in all respects, a decision which constituted the final administrative agency action in this matter. Each state then sought judicial review. Connecticut petitioned for direct appellate review—an action we earlier dismissed for want of jurisdiction, *Connecticut v. Schweiker*, No. 82-4023 (2d Cir. Apr. 20, 1982)—and also filed a complaint in district court seeking reversal of the disallowance.⁴ Ruling on cross motions for summary judgment, Judge Blumenfeld reversed the agency decision, concluding that the IMD definition used by HHS in ordering the disallowance was incompatible with the congressional intent underlying the IMD exclusion. This appeal followed.

(footnote continued)

§ 1396a(10), (20), (21). During the period relevant here, Connecticut did not exercise the option. The HHS audit team conceded that had Connecticut done so, federal financial assistance would have been allowed for the services provided Middletown Haven patients age 65 and over.

The statute requires that the Secretary of HHS recover disallowed Medicaid payments by offsetting such payments against future quarterly advances. 42 U.S.C. § 1396b(d)(2). It cannot be determined from the record whether this procedure has been followed in the instant case. Judge Blumenfeld assumed that once his decision was filed, HHS would “promptly restore any setoff already taken.” *Connecticut v. Schweiker*, 557 F.Supp. at 1091. Again, the record is silent on whether HHS has done so. However, the parties have not requested judicial resolution of the matter.

⁴ Illinois sought direct appellate review of a disallowance and its appeal was also dismissed for want of direct appellate jurisdiction. *Illinois v. Schweiker*, 707 F.2d 273 (7th Cir. 1983). The Seventh Circuit held that if judicial review of the disallowance were available, it would lie initially in district court. 707 F.2d at 279.

Minnesota has secured a declaratory judgment holding that HHS acted improperly in disallowing Medicaid payments made for services provided in three ICF's in that state. *Minnesota v. Heckler*, 718 F.2d 852 (8th Cir. 1983). The Eighth Circuit concluded that HHS had acted improperly in focusing on the diagnosis of patients in its decision that the ICFs at issue were also IMDs. 718 F.2d at 866. We disagree with the Eighth Circuit for reasons set forth *infra*.

We are informed that California has sought district court review of its IMD-based disallowance, but no decision has been reported.

DISCUSSION

Having previously decided that direct appellate jurisdiction is not available in this case, our threshold task is to determine whether jurisdiction exists in any federal court to review the decision of the HHS Departmental Grant Appeals Board. Because the decision is in every sense a “final agency action for which there is no other adequate remedy in a court,” Administrative Procedure Act, 5 U.S.C. § 704 (1976), judicial review is available unless clearly forbidden by Congress. *Abbott Laboratories v. Gardner*, 387 U.S. 136, 140-41 (1967). We agree with the Ninth Circuit that there is no indication that Congress meant to bar review of disallowance decisions, *County of Alameda v. Weinberger*, 520 F.2d 344, 347-49 (9th Cir. 1975), and thus proceed to the merits.

The gravamen of Connecticut's argument is that the IMD exclusion was intended to foreclose federal financial assistance only for services provided in traditional state mental hospitals. Contending that IMD's and ICF's are mutually exclusive categories of institutions, Connecticut maintains that Congress intended that federal assistance be available for the services in question so long as they are provided in ICF's. The policy supposedly underlying this distinction is designed to encourage the placement of mental patients in ICF's, an alternative and favored type of facility. In short, according to Connecticut, what mattered to Congress was not that IMD patients suffered a particular type of illness, but that they were treated in a type of facility that Congress was unwilling to fund.

We disagree with that view of the statute. Both the statutory language and the legislative history demonstrate that, with certain specific exceptions not at issue, Congress has explicitly declined to permit the use of Medicaid funds for custodial care and treatment of the mentally ill under age 65, regardless of the type of facility in which that care and treatment are provided. Because the criteria used by HHS in designating Middletown Haven an IMD seem reasonably tailored to implement this Congressional intent, the disallowance was proper. Accordingly, we reverse.

Our analysis begins with the language of the statute. In Connecticut's view, the most significant statutory provision is the definition of ICF, which explicitly mentions care offered to patients who require it "because of their mental . . . condition." 42 U.S.C. § 1396d(c)(1). Connecticut invokes the inclusion of this language as proof that Congress intended that Medicaid funds be available for services to mental patients provided in ICF's such as Middletown Haven.

There is logic in that argument, but it is not conclusive since the statutory language may refer to ICF treatment of some but not all categories of mental patients. If a state has chosen to extend Medicaid coverage to persons age 65 and over in IMD's, *see supra*, note 3, such persons are covered for mental conditions regardless of whether treatment is provided in a hospital, skilled nursing facility or ICF, *id.* § 1396d(a)(14). The language may thus refer to aged patients with mental illness. Second, the statute clearly provides for the establishment of public ICF's for the treatment of the mentally retarded, *id.* § 1396d(d), and the language may also apply to patients in this category. Third, all parties agree that an ICF is not rendered an IMD simply by providing treatment to some patients who require it because of mental condition; rather, the test is whether the "overall character" of a facility makes it an IMD, 42 C.F.R. § 435.1009. The statutory definition of ICF can logically, therefore, include institutions with mental patients without extending federal assistance to all such patients, since it is clear that some mental patients in ICF's are not excluded from Medicaid assistance.

Like Connecticut, HHS relies upon a statutory provision which it regards as conclusive. That provision authorizes the payment of Medicaid funds for "intermediate care facility services (other than such services in an institution for . . . mental diseases)." 42 U.S.C. § 1396d(a)(15). In HHS's view, Congress forbade the use of Medicaid funds to cover ICF services provided in an IMD, a term which Congress did not define but which HHS has reasonably construed to include any institution primarily engaged in the treatment of

mental diseases. 42 C.F.R. § 435.1009. Connecticut rejoins that the ban on reimbursement for ICF services provided in an IMD simply means that ICF services are not covered only if they are provided in a type of institution excluded under the statute, *i.e.* the IMD or traditional mental hospital. In Connecticut's view, Congress phrased the exclusion in order to prevent states from obtaining Medicaid reimbursement for ICF-level services provided in traditional mental hospitals; conversely, it argues, so long as ICF services are offered in independent ICF's, Congress intended that Medicaid funds be available. Thus, Connecticut argues, because ICF's and IMD's are mutually exclusive types of facilities and Congress did not contemplate circumstances under which an ICF would be confused with an IMD, the exclusion for ICF services rendered in an IMD is irrelevant.

We believe HHS's view is the more plausible. First, Connecticut's reading asks us to believe that, while Congress intended to encourage the use of ICF's, it expressly forbade financial assistance to effect even the partial transformation of state mental hospitals into ICF's. We perceive no reason whatsoever to conclude that Congress intended to deter the development of ICF's within the traditional hospital, particularly since transforming part of an existing facility might be considerably less expensive than development of a new institution. The distinction proffered by Connecticut treats an ICF operated within an IMD differently from an independent ICF even though the nature of the patients treated and services offered are identical. No congressional purpose calling for such an artificial distinction has been offered, and we have found none in our independent research.

Second, the statutory language strongly suggests that Congress believed that even an independent ICF which provided care and services to the mentally ill might be an IMD. Congress authorized the payment of Medicaid funds for "inpatient hospital services (other than services in an institution for . . . mental diseases)," 42 U.S.C. § 1396d(a)(1), for "skilled nursing facility services (other than services in an institution for . . . mental diseases)," *id.* § 1396d(a)(4A), and

"intermediate care facility services (other than such services in an institution for . . . mental diseases)," *id.* §1396d(a)(15). Unless one accepts the artificial distinction between an ICF operated independently of an IMD and an ICF connected with an IMD, these identical exclusions strongly imply that Congress contemplated that any of the three types of facilities—the hospital, the skilled nursing facility and the ICF—might qualify under certain circumstances as an IMD. Moreover, the definition of an ICF states that "the term 'intermediate care facility' shall not include . . . any public institution . . . for mental diseases or mental defects," 42 U.S.C. § 1396d(c), except for public ICFs "for the mentally retarded or persons with related conditions," *id.* § 1396d(d). Since the exclusion for IMD's does not distinguish between public and private facilities, the combination of Sections 1396d(a)(15), 1396d(c) and 1396d(d) makes sense only as a statement that ICF's which are IMD's are excluded from the definition except those public ICF/IMD's which care for the mentally retarded. In short, the provisions are meaningless unless some ICF's are IMD's and thus subject to the statutory exclusion.

A review of the legislative history fully supports the view that these provisions are not meaningless but the result of a conscious congressional design to support care for the elderly suffering from mental illness, including the encouragement of alternatives to the traditional mental hospital, while excluding coverage to those under age 65. The forerunner of the IMD exclusion was enacted in 1950, when Congress authorized the payment of federal old-age assistance to the elderly residing in public medical institutions.⁵ Social Security Amendments of 1950, Pub. L. No. 81-734, § 303(a), 64 Stat. 477, 549. Congress refused, however, to authorize such payments for the elderly residing in "public or private institutions for mental illness or tuberculosis," on the grounds that care of such patients traditionally had been the responsibility of the states, H.R. Rep. No. 1300, 81st Cong., 1st Sess. 42 (1949).

⁵ Such assistance previously had been available only to the elderly residing in private institutions. H. R. Rep. No. 1300, 81st Cong., 1st Sess., 42 (1949).

The original IMD exclusion, as amended,⁶ continued in force until 1965, when Congress enacted the Medicaid statute and established a comprehensive program of federal financial assistance for medical care to the indigent. That statute made federal financial assistance for the treatment of the mentally ill dependent on age. With respect to care provided the indigent mentally ill under age 65, no federal funds were available for treatment in IMD's, but such funds were available for treatment provided in general hospitals. With respect to the indigent over 65, the Medicaid statute omitted an IMD exclusion analogous to the one which was enacted some fifteen years before. An expressly stated purpose behind lifting the IMD exclusion for those over 65 was to encourage states to permit the elderly to receive mental health care in a variety of settings that would serve as alternatives to confinement in the traditional mental hospitals; among these alternatives were nursing homes, general hospitals and foster families, S. Rep. No. 404, Pt. 1, 89th Cong., 1st Sess. 145, *reprinted in* 1965 U.S. Code Cong. & Ad. News 1943, 2084-87. Indeed, state access to Medicaid funds for the treatment of aged persons in IMD's was contingent on the development of state plans for the provision of alternative forms of mental health care to the elderly. Social Security Amendments of 1965, Pub. L. No. 89-97 § 121(a), 79 Stat. 286, 347 (codified at 42 U.S.C. § 1396a(20), (21)); *see* S. Rep. No. 404, *supra*, at 145.

Much of Connecticut's argument that Congress intended to encourage the provision of alternative care to that provided in traditional mental hospitals is actually drawn from legislative history explaining Congress' decision to lift the IMD exclusion as to *the elderly*. *See, e.g.*, Brief of Appellee at 18-19. Similarly, congressional discussion of alternative types of care took place in the context of treatment provided to *the elderly*. *See, e.g.*, S. Rep. No. 404, *supra*, at 145. Lengthy and repeated quotation from the legislative history concerning alternative types of care

⁶ In 1960 Congress modified the IMD exclusion to permit payment for the first six weeks of care in a "medical institution" for the aged who required such care "as a result of a diagnosis of . . . psychosis." Social Security Amendments of 1960, Pub. L. No. 86-778, § 601(2)(f)(2), 74 Stat. 924, 991.

for the elderly merely underlines the absence of any such history supporting Connecticut's position as to persons under age 65, a central issue in the instant litigation. The fundamental and ultimately fatal weakness of Connecticut's argument is the undeniable fact that Congress has never lifted the longstanding IMD exclusion for persons under age 65 or even indirectly implied such a purpose in the legislative history.

To the contrary, on at least three of the occasions on which Congress amended the Medicaid program in the seven years after 1965, explicit proposals to lift the IMD exclusion as to those under age 65 were made in hearings on the Medicaid legislation to no avail. On each occasion a proposal was made to make Medicaid funding available for the treatment for the mentally ill under age 65, not simply in traditional mental hospitals, but also in alternative treatment settings. In 1967 the Senate Finance Committee was told during hearings on Medicaid legislation that the effect of the broad availability of Medicaid funds for the treatment of the elderly mentally ill was to permit "the psychiatrist to utilize the full range of modern psychiatric facilities for the treatment of the older patient," but that the effect of the IMD exclusion for the population under age 65 was to preclude Medicaid funds for the treatment of the mentally ill under age 65 in any "mental institution, whether it be a public or private mental hospital, or even a community health center." Social Security Amendments of 1967: Hearings on H.R. 12080 Before the Senate Comm. on Finance, Pt. 3, 90th Cong., 1st Sess. 1741 (1967) (Statement of Dr. Robert W. Gibson, Am. Psychiatric Ass'n). Nevertheless, Congress refused to act.

This appeal was renewed in Senate hearings in 1970, and once again Congress refused to change the law. See Social Security Amendments of 1970: Hearings on H. R. 17550 Before the Senate Comm. on Finance, Pt. 2, 91st Cong., 2d Sess. 500-50 (1970). Moreover, in the same hearings, supporters of expanded federal assistance for the mentally ill and mentally retarded protested the House's modification of the statutory definition of an ICF.⁷ See, e.g., *id.* at 504-09 (Testimony of

⁷ Federal funding had been available since 1967 for ICF care provided to the aged, the blind, and the totally and permanently disabled. See *supra*.

Kenneth D. Gaver, M.D., Administrator, Or. Div. Mental Health). The House language modified the ICF definition to exclude "any public institution (or distinct part thereof) for mental diseases or mental defects." H. R. 17550, 91st Cong., 2d Sess. § 225(b)(2) (1970). The Senate was warned by those proposing expanded financial assistance to the mentally ill that for those patients eligible for federally supported ICF services, this language would forbid "a supportive program of care of a semimedical nature" for the mentally ill and a "supportive program of care of a social service-rehabilitative type" for the mentally retarded. *Id.* at 501-02 (Testimony of Harry Schnibbe, Executive Director, Nat'l Ass'n of State Mental Health Program Directors). When ICF services were made part of the Medicaid program in December, 1971, the language passed by the House in reference to the earlier ICF program was retained but modified to permit support for public ICF's treating the mentally retarded. Pub. L. No. 92-223, § 4, 85 Stat. 802, 809 (1971) (codified at 42 U.S.C. § 1396d(c), (d)). For present purposes the most conspicuous feature of the statutory definition of an ICF is the absence of any provision authorizing public ICF's for the mentally ill, although this too had been sought in the hearings before the Senate Finance Committee. This episode thus suggests two conclusions: (1) Congress did not consider ICF's and IMD's as mutually exclusive categories; and (2) Congress declined to enact an ICF definition which included ICF's treating the mentally ill, although it was explicitly asked to do so.

The third, and for purposes of our inquiry most important, effort to eliminate the IMD exclusion occurred in January, 1972. See Social Security Amendments of 1971: Hearings on H.R. 1 Before the Senate Comm. on Finance, Pt. 2, 92nd Cong., 1st & 2nd Sess. 924 (1972) (Statements of Dr. Jonathan Leopold, Comm'r, Vt. Dept. of Mental Health & Dr. Kenneth Gaver, Comm'r, Ohio Dept. of Mental Hygiene & Corrections). In these hearings, which occurred some three weeks after passage of the legislation which brought ICF coverage under the Medicaid program and which Connecticut claims is dispositive of this litigation, the Senate Finance Committee heard for the

third time an appeal by state mental health officials to lift the IMD exclusion for those under age 65. As part of this appeal, the salutary consequences of lifting the IMD exclusion for the aged were described; one such consequence was that elderly patients were discharged from traditional state mental hospitals "into nursing homes, into *intermediate care facilities*" and into other alternative settings. *Id.* at 928 (emphasis added). The state officials argued that "[t]he principle of equity requires that the benefits presently provided to mentally ill persons over 65 be made available to persons of all ages." *Id.* at 929. These officials thus believed that under the then existing statutory framework—a framework virtually identical to the one at issue in the instant litigation—states could not discharge patients under age 65 from mental hospitals, arrange their placement in ICF's and then look to the Medicaid program for financial support.

Responding to this presentation, Senator Long, Chairman of the Senate Finance Committee and a key political figure in the legislative process, warned state officials that their proposal would be perceived as too costly and asked whether as an alternative they would "support an amendment to cover the mentally ill [under age 65] under Medicaid who receive active care and treatment in an accredited medical institution." *Id.* at 929. Ultimately, Congress provided even less than the compromise offered by Senator Long, for it approved only limited relief from the IMD exclusion by permitting the use of Medicaid funds for inpatient psychiatric hospital services to patients under age 21. Pub. L. No. 92-603, § 299B, 86 Stat. 1329, 1460-61 (1972) (codified at 42 U.S.C. § 1396d(a)(16),(h)). A pilot program approved by the Senate to test "the potential benefits of extending medicaid mental hospital coverage to mentally ill persons between the ages of 21 and 65" was rejected by the House and dropped in conference. *See* S. Rep. No. 1230, 92d Cong., 2d Sess. 57; H. R. Rep. No. 1605, 92d Cong., 2d Sess. 65 (Conf. Rep.), *reprinted in* 1972 U.S. Code Cong. & Ad. News 5370, 5398. The IMD exclusion thus remained virtually in full force, as Congress declined to extend full Medicaid coverage for the treatment of the mentally ill between the ages of 21 and 65.

The import of this legislative history is clear. The IMD exclusion was perceived to block the use of Medicaid funds to help pay for the care of the mentally ill under age 65 in a broad range of institutions subsumed under the label "institution for mental diseases," including ICF's. Congress was asked repeatedly to lift this exclusion in whole or in part and refused.

Against this record of legislative history, Connecticut offers only a statement prepared by the Senate Finance Committee and offered by Senator Long in support of the December, 1971 legislation transferring ICF coverage to the Medicaid program. The statement declared that "intermediate care coverage is for persons with health-related conditions who require care beyond residential care or boarding home care, and who, in the absence of intermediate care would require placement in a skilled nursing home or mental hospital." 117 Cong. Rec. 44,721 (1971). Connecticut argues from this that Congress intended that Medicaid funding be available for services provided to all patients who otherwise would be in a mental hospital subject to the IMD exclusion. One need not interpret this language so broadly, however. The legislation effecting the transfer made the IMD exclusion applicable to ICF services provided patients under age 65 and was considered by Senator Long to bar Medicaid funding for services provided patients under 65 discharged from mental hospitals and placed en masse in ICF's, as he implicitly acknowledged in the Finance Committee hearings which took place some six weeks after the quoted statement. Given that the Senate Finance Committee statement also speaks of the transfer of ICF coverage from Title XI, federal old age assistance, to the Medicaid program in order to subject ICF's to federal standards and to reduce the placement of patients in skilled nursing facilities who only required less expensive ICF care, *id.*, it is wholly plausible to conclude that the quoted language refers to ICF services available to the elderly and not subject to the IMD exclusion.

For the foregoing reasons we are convinced that the IMD definition adopted by HHS and supplemented by its internal criteria reasonably implements Congress' intent. Connecticut's

principal complaint is that the IMD definition and criteria adopted by HHS improperly focus on the nature of patients' illnesses rather than the type of care furnished at the facility in question. However, the IMD exclusion virtually compels HHS to focus on the nature of the illnesses treated rather than the care furnished. Except for the use of Medicaid funds to treat the mentally ill under age 65 in general hospitals and patients under age 21 in psychiatric hospitals, Congress has not modified the IMD exclusion to differentiate among types of custodial facilities treating the mentally ill. It is not for us to disturb this decision.

Reversed and remanded for entry of judgment consistent with this opinion.

APPENDIX B

United States Court of Appeals

FOR THE SECOND CIRCUIT

At a stated Term of the United States Court of Appeals for the Second Circuit, held at the United States Courthouse in the City of New York, on the thirtieth day of March, one thousand nine hundred and eighty-four.

PRESENT:

HON. WALTER R. MANSFIELD

HON. AMALYA L. KEARSE

HON. RALPH K. WINTER

Circuit Judges,

83-6105

STATE OF CONNECTICUT,
DEPARTMENT OF INCOME MAINTENANCE,
Plaintiff-Appellee,

v.

MARGARET M. HECKLER, SECRETARY, and
The UNITED STATES DEPARTMENT OF HEALTH
AND HUMAN SERVICES,
Defendants-Appellants.

(filed March 30, 1984)

Appeal from the United States District Court
for the District of Connecticut.

This cause came on to be heard on the transcript of record from the United States District Court for the District of Connecticut, and was argued by counsel.

ON CONSIDERATION WHEREOF, it is now hereby ordered, adjudged, and decreed that the order of said District Court be and it hereby is reversed and the action be and it hereby is remanded to the said district court for further proceedings in accordance with the opinion of this court with costs to be taxed against the appellee.

ELAINE B. GOLDSMITH,
Clerk

/s/ Edward J. Guardaro,

By: Edward J. Guardaro,
Deputy Clerk

APPENDIX C

United States District Court

DISTRICT OF CONNECTICUT

CIVIL NO. H-82-146

STATE OF CONNECTICUT,
DEPARTMENT OF INCOME MAINTENANCE

v.

RICHARD S. SCHWEIKER, SECRETARY, AND THE UNITED
STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES

RULING ON CROSS-MOTIONS FOR SUMMARY JUDGMENT

(filed February 17, 1984)

I. PROCEDURAL HISTORY

In this suit, the State of Connecticut challenges the final administrative decision by the Department of Health and Human Services (HHS) that Connecticut's expenditures to the privately owned Middletown Haven Rest Home are not eligible for federal reimbursement under the Medicaid program, Title XIX of the Social Security Act (codified as amended at 42 U.S.C. §§ 1396-1396m (1976 & Supp. IV 1980) and 42 U.S.C.A. §§ 1396-1396n (West 1974 & Supp. 1981)).

HHS¹ advanced funds quarterly to Connecticut for expenses for patient care at Middletown Haven Rest Home. The advances covered the period from the home's opening in January 1977 through September 1979. This advance of funds was pursuant to 42 U.S.C. § 1396b(d)(2) (1976), as Con-

¹ Until 1980, the role of HHS was played by HHS's predecessor, the Department of Health, Education and Welfare (HEW). For convenience, I refer only to HHS.

necticut had identified Middletown Haven as an "intermediate care facility" (ICF) eligible for reimbursement under 42 U.S.C. § 1396d(a)(15) (1976). In 1980, following an audit of Middletown Haven covering the above time period, the Health Care Financing Administration (HCFA) of HHS decided that the expenses at Middletown Haven had in fact not qualified for reimbursement because Middletown Haven, though an ICF, was also an "institution for mental diseases" (IMD), 42 U.S.C. §§ 1396d(a)(15), 1396d(a)(B) (1976). HCFA thus disallowed the federal reimbursement. Connecticut appealed this decision to the HHS Departmental Grant Appeals Board. The board sustained HCFA in Decision No. 231, dated November 30, 1981 (hereinafter, Decision 231). Having made this decision, HHS is required to offset the disallowed payments from future quarterly advances. 42 U.S.C. § 1396b(d)(2) (1976).² Connecticut appeals this final administrative decision.

II. JURISDICTION

A threshold matter is this court's jurisdiction.³ The Board's decision is a "final agency action for which there is no other adequate remedy in a court." Administrative Procedure Act (APA) § 704, 5 U.S.C. § 704 (1976). Accordingly, judicial review is available unless the particular statutes concerning the Board's action "preclude judicial review." APA § 701(a), 5 U.S.C. § 701(a) (1976). Judicial review is not deemed forbidden unless the statute clearly forbids review. *Abbott Laboratories v. Gardner*, 387 U.S. 136, 140-41 (1967). Here, 42 U.S.C.A. § 1316(d) (West Supp. 1981) requires the Secretary to review disallowances but is silent on further review in the courts. Accordingly, review seems permitted by the doctrine of *Abbott Laboratories*. Further, the court in *County of Alameda v. Weinberger*, 520 F.2d 344, 347-49 (9th Cir. 1975) (Hufstedler, J., joined by Browning and Koelsch, JJ.), in

² A 1980 amendment allows the state to retain disallowed advances pending judicial review, but the amendment applies only to expenditures for services furnished on or after October 1, 1980. 42 U.S.C. § 1396b(d)(5) (Supp. IV 1980).

³ HHS does not challenge this court's jurisdiction, but this court has an independent duty to examine whether it has jurisdiction.

considering the text, legislative history, and policy of section 1316(d), found no indication that Congress intended to preclude judicial review.⁴

Review of actions under section 1316(d) lies in the district court, which has subject matter jurisdiction by 28 U.S.C. § 1331 (Supp. IV 1980) (amending 28 U.S.C. § 1331 (1976)). See *Alameda*, 520 F.2d at 347, 349 (implicitly assuming that review under section 1316(d) lies in district court, and upholding such review). See also K. Davis, *Administrative Law Treatise* § 23.03-1 at 373 (Supp. 1982) (provision in APA section 703 for review in "court of competent jurisdiction" means, in absence of contrary statute, review in district court, which has general jurisdiction under 28 U.S.C. §§ 1331, 1337).⁵

⁴ The *Alameda* court's reasoning seems applicable to any disallowance controlled by section 1316(d). Nevertheless, the court, in finding judicial review permitted, expressly limited its holding to the situation in which the agency had already used "self-help setoff procedures" to collect the amount disallowed. 520 F.2d at 349 n.11. The case at bar is little different, because, as mentioned, the Secretary is required to offset the amount disallowed against future quarterly payments, and presumably he has done so.

⁵ One might argue that review of the Secretary's action is controlled not by section 1316(d) but by section 1316(a), 42 U.S.C.A. § 1316(a) (West 1974 & Supp. 1981), which provides for review in the court of appeals of the Secretary's disapproval of a state plan. On this question, I find persuasive the opinion of Chief Judge Lord in *Minnesota v. Schweiker*, No. 4-82-155 Civ., slip op. at 3-5 (D. Minn. Aug. 25, 1982). Judge Lord's case involved a disallowance very similar to the one in this case. Both disallowances were based on the agency's determination, after audit, to disallow funds previously advanced for care at an intermediate care facility (ICF) because the facility was also an institution for mental diseases (IMD). The cases were heard together by the HHS Departmental Grant Appeals Board, and were decided together by the Board in Decision 231. Judge Lord reviewed several cases near the boundary between sections 1316(a) and 1316(d), including the recent Third Circuit case of *New Jersey v. Department of Health and Human Services*, 670 F.2d 1300 (3d Cir. 1982), and concluded that the disallowance in question came under section 1316(d) rather than section 1316(a) because it did "not concern the validity of Minnesota's Medicaid plan or its overall administration" but rather was "narrowly focused upon specific reimbursement claims." Slip op. at 4-5. The same reasoning applies here.

III. THE PRESENT MOTIONS

In its complaint, Connecticut challenges HHS' action in various ways. First, the finding that Middletown Haven Rest Home was an IMD is allegedly contrary to statute, ¶¶ 19-21, contrary to regulations, ¶¶ 23-24, and based on arbitrary criteria (of which Connecticut had insufficient notice) for classifying facilities as IMDs, ¶ 26. Next, Connecticut attacks the alleged retroactive nature of the disallowance. ¶ 28. Finally, Connecticut challenges the Board's action as not supported by substantial evidence. ¶ 30.

Connecticut and HHS have both moved for summary judgment. There is some confusion over whether Connecticut's claim concerning substantial evidence is before the court on these motions. See Defendant's Brief at 22 n.10; Plaintiff's Reply Brief at 16 n.1; Defendant's Reply Brief at 2 n.*; Plaintiff's Supplemental Brief at 6 n.*.⁶ However, the issue of statutory construction, which is definitely before the court on these motions, is sufficient to decide the motions.

⁶ The parties have each submitted three briefs on the cross-motions for summary judgment. In order received, they are:

1. [Plaintiff's] Brief in Support of Plaintiff's Motion for Summary Judgment
2. Defendant's Memorandum in Support of Cross-Motion for Summary Judgment and in Opposition to Plaintiff's Motion for Summary Judgment
3. Plaintiff's Reply Brief
4. Defendant's Reply Memorandum in Support of Motion for Summary Judgment
5. [Defendant's] Supplemental Brief in Support of Defendant's Cross-Motion for Summary Judgment
6. Plaintiff's Response to Defendant's Supplemental Brief.

The court will refer to these briefs respectively as:

1. Plaintiff's Brief
2. Defendant's Brief
3. Plaintiff's Reply Brief
4. Defendant's Reply Brief
5. Defendant's Supplemental Brief
6. Plaintiff's Supplemental Brief.

The Supplemental Briefs discuss *Minnesota v. Schweiker*, No. 4-82-155 Civ. (D. Minn. Aug. 25, 1982), which was decided after this court heard oral argument on the summary judgment motions.

IV. STATUTORY CONSTRUCTION: THE VARIOUS POSITIONS

This case depends on the meaning of "institution for mental diseases" (IMD) in the Medicaid statute. The reason is that Middletown Haven qualifies for federal payments as an "intermediate care facility" (ICF) unless it is also an IMD.

The Medicaid statute provides for the federal government to share with states the costs of "intermediate care facility services (other than such services in an institution for tuberculosis or mental diseases)." 42 U.S.C. § 1396d(a)(15) (1976). An "intermediate care facility" (ICF) is

an institution which (1) is licensed under State law to provide, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities, [and also meets the Secretary's care, safety, and sanitation standards]

42 U.S.C. § 1396d(c) (Supp. IV 1980) (amending 42 U.S.C. § 1396d(c) (1976)). The statute repeats that the federal payments do not include "any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for tuberculosis or mental diseases." 42 U.S.C. § 1396d(a)(B) (1976). Thus, though ICFs in general are eligible for federal payments, ICFs which are also IMDs are ineligible.

The Grant Appeals Board, while it accepted Middletown Haven's ICF status, disallowed funds on the ground that Middletown Haven was also an IMD. Decision 231 at 35-39. In determining whether Middletown Haven was an IMD, the Board followed HHS regulations which define an IMD as a facility with the "overall character" of being "primarily for the

care and treatment of individuals with mental diseases.”⁷ *Id.* at 39. The Board found this definition satisfied by a combination of facts. The most important fact was that a large majority of the patients were “mental” patients. *Id.* at 36-37. Other facts included Middletown Haven’s license to care for persons with psychiatric conditions, Middletown Haven’s having advertised itself as a facility specializing in the care of persons with mental diseases, and the presence of three staff psychiatrists who made weekly consultations. *Id.* at 36.

The Board’s decision can be upheld only if its classification of Middletown Haven was based on appropriate factors. Accordingly, HHS maintains in this court that an ICF is an IMD if it exists primarily to care for mental patients. Defendant’s Brief at 9-10. Connecticut, in contrast, asserts that an “IMD” means a “state mental hospital or its private equivalent.” Plaintiff’s Brief at 17. Connecticut is substantially correct. An IMD means a mental hospital, which in turn means, at the least, a facility providing total care to mental patients.⁸

⁷ HHS regulations define an IMD as

an institution that is *primarily* engaged in providing diagnosis, treatment or care of *persons with mental diseases*, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained *primarily for the care and treatment of individuals with mental diseases*, whether or not it is licensed as such

42 C.F.R. § 435.1009 (1980) (emphasis added). In turn, the regulations define an “institution” as

an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor.

Id.

⁸ I thus disagree with Chief Judge Lord in *Minnesota v. Schweiker*, No. 4-82-155 Civ., slip op. at 15 (D. Minn. Aug. 25, 1982), who concluded in a case very similar to the case at bar, *see supra* note 5, that “by ‘institution for mental diseases’ the Congress intended to refer to those institutions which provided primarily long-term care for the mentally ill by administering psychiatric treatment for its residents on the premises.” I disagree because, as discussed below, the legislative history indicates on balance that long-term care and psychiatric care are not necessary for a facility to be an IMD, but that total care is. Though I disagree with Judge Lord’s conclusion, I have greatly benefited from his insightful opinion.

V. STATUTORY CONSTRUCTION: ANALYSIS

A. *The Ambiguity of the Term “IMD”*

The phrase “institution for mental diseases” used in sections 1396d(a)(15) and 1396d(a)(B) is not self-explanatory. “Institution” suggests a total care situation, probably for a long time.⁹ Consider, for example, the meaning of “to institutionalize” someone. “Institution” also suggests a large, impersonal establishment. Contrast the more neutral term “facility,” used often elsewhere in the statute. Still, “institution” might simply be used in a neutral sense, as a synonym for “facility”; or it might, for example, denote a fairly high but not total level of care. Further, the phrase “for mental diseases” might require only that patients have mental diseases, or it might require also that some level of psychiatric treatment be given.

To discover the meaning of “IMD,” first the statute’s text and then its legislative history will be examined.

B. *Clues from the Statute’s Text*

The statute’s text is only slightly helpful in resolving the ambiguous meaning of “IMD.” Three sections are relevant: sections 1396d(a), 1396d(c), and 1396a. 42 U.S.C.A. §§ 1396a, 1396d (West 1974 & Supp. 1981).

Section 1396d(a). By excluding services in an IMD from the general cost sharing of ICF services, section 1396d(a)(15), quoted *supra* p. 6, implies that ICFs may also be IMDs, but does not clarify under what circumstances this would happen. Parallel IMD exclusions in parts (1) and (4) of section 1396d(a), dealing with inpatient hospital services and skilled nursing facility services respectively, imply that these other facilities too can be IMDs, but again do not clarify just how this would happen. The same message comes from part (14), which explicitly covers “inpatient hospital services, skilled nursing facility services, and intermediate care facility services for individuals 65 years of age or over in an institution for tuberculosis or mental diseases.”

⁹ By “total care” I mean the very high level of care given, for example, to a hospital inpatient or a nursing home resident. The patient is totally dependent on the institution and is submerged in it.

Section 1396d(c). Section 1396d(c), quoted *supra* p. 6, defines an ICF as providing care required by patients' "mental or physical condition." This language suggests that people with mental and physical conditions ("mental patients" and "physical patients" respectively) should be treated equally. From this viewpoint, a definition of an IMD as an institution maintained primarily for mental patients would be undesirable because it would discriminate fairly directly against mental patients. A definition of an IMD at least partly in other terms, such as a requirement of total care, would discriminate much less efficiently against mental patients. Other possible defining criteria can be similarly evaluated. For example, the criterion that the facility provide psychiatric care would discriminate against mental patients more than the criterion that the facility provide total care, but less than the criterion that the facility exist primarily for mental patients.

Section 1396a. Section 1396a(21) lists "community mental health centers" as an example of "alternatives to care in public institutions for mental diseases." This section thus suggests that a "community mental health center" is not an IMD. However, it is not immediately clear what a "community mental health center" is, and whether Middletown Haven is one. Further, Congress in this section may have contemplated a *private* community mental health center, which merely because it is private is not a "*public* institution for mental diseases" (emphasis added).¹⁰

¹⁰ Section 1396a(21) speaks of "community mental health centers, nursing facilities, and other alternatives to care in public institutions for mental diseases." Section 1396a(20) discusses "alternate plans of care" to care in (public or private) "institutions for mental diseases," but it mentions no examples.

HHS suggests that the term "public institution for mental diseases" may have a more restrictive meaning than simply a public "institution for mental diseases." See Defendant's Brief at 10 n.6. This idea is plausible, and if correct it could invalidate inferences from the meaning of "public institution for mental diseases" to the meaning of "institution for mental diseases." However, this idea is counterintuitive, and HHS does not support it.

C. Legislative History

Legislative history, by explaining the purpose behind the IMD exclusion, indicates a definition for "IMD." Further, by illuminating two of the three suggestive statutory sections just discussed, legislative history further supports this definition. Relevant legislation occurred in 1950, 1960, 1963, 1965, 1967, 1971, and 1972.¹¹

1. The Purpose of the IMD Exclusion

The legislative history reveals two broad points. First, by the IMD exclusion, Congress meant to exclude state "mental hospitals" because the states were already funding them. Next, by a "mental hospital" Congress meant, at the least, a facility which provides total care to mental patients.

An IMD exclusion for Social Security was first enacted in 1950 for the old-age medical assistance program of Title I. 1950 Act, sec. 303, § 6, 64 Stat. at 549. This legislation

¹¹ I will refer to these acts as, e.g., "the 1950 Act." The full citations for these seven acts, with their relevant provision summarized in parentheses, are:

- 1950: Social Security Act Amendments of 1950, Pub. L. No. 81-734, 64 Stat. 477, 549 (sec. 303, § 6, IMD exclusion for Title I).
- 1960: Social Security Amendments of 1960, Pub. L. No. 86-778, 74 Stat. 924, 991 (sec. 601, amending Title I IMD exclusion).
- 1963: Community Mental Health Centers Act of 1963, Title II of Pub. L. No. 88-164, 77 Stat. 282, 290-94 (funding construction of community mental health centers).
- 1965: Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286, 343-52 (sec. 121, enacted Title XIX, with IMD exclusion for those under age 65).
- 1967: Social Security Amendments of 1967, Pub. L. No. 90-248, 81 Stat. 821, 920 (sec. 250(a), § 1121, ICF coverage under Title XI).
- 1971: Pub. L. No. 92-223, 85 Stat. 802, 809 (sec. 4, § 1905, ICF coverage under Title XIX).
- 1972: Social Security Act Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1329, 1459-60 (sec. 295, clarifying coverage of ICF care in IMDs for those over 65).

Of these seven acts, the 1950, 1960 and 1967 Acts concern other Social Security titles; the 1963 Act does not concern Social Security; and the 1965, 1971 and 1972 Acts concern Social Security Title XIX.

provided for payment for medical care of individuals aged 65 or older in public and private institutions, excluding any individual "who is a patient in an institution for tuberculosis or mental diseases."¹² The House Committee on Ways and Means explained that the then current law permitted assistance to persons in private institutions but not those in public ones. However, the "needy aged persons who are chronically ill" could not find affordable private institutions for care. Federal payments for care in public institutions would encourage the admission of needy persons to existing public facilities as well as the development of additional public facilities. H.R. Rep. No. 1300, 81st Cong., 1st Sess. 42 (1949). The bill however excluded "assistance to persons residing in public or private institutions for mental illness and tuberculosis, since the States have generally provided for medical care of such cases." *Id.*

In 1965, Congress enacted the Medicaid program as Title XIX of the Social Security Act. This Title contains the provisions at issue in this case. Congress included in 1965 the same IMD exclusion that is now codified at 42 U.S.C. § 1396d(a)(B), quoted *supra* pp. 6-7. 1965 Act, sec. 121, § 1905(a)(B), 79 Stat. at 352. In contrast to the 1950 IMD exclusion (which applied in a title dealing only with individuals aged 65 and over), the 1965 IMD exclusion by its terms affected only individuals under age 65.¹³

¹² In the same sentence, the 1950 Act also excluded any individual "who has been diagnosed as having tuberculosis or psychosis and is a patient in a medical institution as a result thereof." Benefits for such patients for up to 42 days were granted in 1960. 1960 Act, sec. 601(f), 74 Stat. at 991.

¹³ Why did Congress single out the aged to receive IMD benefits? Apparently for two reasons. First, Congress had excluded IMDs in part because of the long-term care involved. But with the progress made in care for the mentally ill, care for the *aged* mentally ill was no longer much longer-term on the average than other care for the aged. Second, the line for old persons between mental illness and senility was hard to draw. Thus, an IMD exclusion would have posed a tough classification problem, and would also have discouraged appropriate patient transfer from one kind of facility to another. See Statement of Sen. Carlson, 110 Cong. Rec. 21349 (1964) (by implication).

HHS argues that Congress removed the IMD exclusion for those 65 and over in order to fund alternatives to mental hospitals in treating the aged

(footnote continues)

Congress excluded IMDs from funding because the states had traditionally funded care in mental hospitals. The Senate Finance Committee and the House Ways and Means Committee both stated that the "reason for this exclusion was that long-term care in such hospitals had traditionally been accepted as a responsibility of the States." S. Rep. No. 404, Part I, 89th Cong., 1st Sess. 144, reprinted in 1965 U.S. Code Cong. & Ad. News 1943, 2084; H.R. Rep. No. 213, 89th Cong., 1st Sess. 126 (1965).¹⁴ Similarly, Secretary Celebreeze explained: "Under the bill, institutions providing care primarily for mental or tuberculosis patients are excluded from participation. The main reason for this exclusion is that most of these hospitals are public institutions and are supported by public funds. Nor did it seem reasonable to cover private but not public institutions." *Social Security; Medical Care for the Aged Amendments: Hearings on H.R. 11865 Before the Senate Comm. on Finance*, 88th Cong., 2d Sess. 108 (1964). See also House Comm. on Ways and Means, 89th Cong., 1st Sess., *Summary of Major Provisions of Medical Assistance for the Aged Program 1* (Comm. Print 1965) ("The Federal Government does not

(footnote continued)

mentally ill. Thus, HHS concludes, Congress considered such alternative treatments as coming within the IMD exclusion. HHS points to the Senate Finance Committee report, Defendant's Brief at 15-16; however, the report does not support HHS' position. First, the report notes the increased treatment success, in mental hospitals and elsewhere, as a reason for considering mental illness on a par with physical illness. S. Rep. No. 404, Part I, 89th Cong., 1st Sess. 144, reprinted in 1965 U.S. Code Cong. & Ad. News 1943, 2084. Next, the report notes Congress' policy of encouraging alternative care, and explains that, as a condition to receiving funds for care for aged persons in IMDs, states are required to develop plans for use, when appropriate, of alternative care. *Id.* at 145, 1965 U.S. Code Cong. & Ad. News at 2085. Far from indicating that alternative care was before 1965 subject to the IMD exclusion, the report consistently contrasts "hospital," "institution," "institutional treatment," and "institutions for mental disease" on the one hand with alternative care on the other. *Id.* at 144-47, 1965 U.S. Code Cong. & Ad. News at 2084-87.

¹⁴ The House version substituted "generally" for "traditionally."

In the quoted passage, the committees were describing the reasons for the IMD exclusion before 1965. However, in each case the committee was considering the 1965 IMD exclusion in the same light.

participate in respect to medical services furnished ... to patients in mental or tuberculosis hospitals.")¹⁵

Courts have echoed this interpretation of the 1965 IMD exclusion as referring to hospitals. A three-judge district court upheld the IMD exclusion against an equal protection challenge by finding a rational basis for the exclusion in Congress' "belief ... that care of the mentally ill in state hospitals was the responsibility of the states." *Legion v. Richardson*, 354 F.Supp. 456, 459 (S.D.N.Y.) (Stewart, J., joined by Feinberg, Cir. J., and Gurfein, J.), *aff'd sub nom. Legion v. Weinberger*, 414 U.S. 1058 (1973). In another equal protection case, the Supreme Court noted this policy behind the 1965 IMD exclusion to infer by analogy a rational basis for the exclusion of Title XVI Supplemental Security Income benefits from persons aged 21 through 64 residing in public mental institutions. *Schweiker v. Wilson*, 450 U.S. 221, 236-37 & n.19 (1981) (quoting *Legion v. Richardson* as well as "hospital" language in the Senate report).

¹⁵ In contrast, state funding of alternatives to mental hospitals was most inadequate. In the early 1960's, alternatives to state mental hospitals were badly needed and not present in large quantity. H.R. Rep. No. 694, 88th Cong., 1st Sess., reprinted in 1963 U.S. Code Cong. & Ad. News 1054, 1064-65. Congress envisioned alternative care to come from "comprehensive community mental health centers" which would include "an emergency psychiatric unit, inpatient services, outpatient services, day and night care, foster home care, rehabilitation programs, and general diagnostic and evaluation services." *Id.*, 1963 U.S. Code Cong. & Ad. News at 1065. Such centers would "transfer the care of the mentally ill from State custodial institutions to community facilities and services comparable to the facilities and services provided at the community level for those who are physically ill." *Id.*, 1963 U.S. Code Cong. & Ad. News at 1058. In 1965, Congress still noted a strong need to provide more of such alternative care. S. Rep. No. 404, Part I, 89th Cong., 1st Sess. 145-47, reprinted in 1965 U.S. Code Cong. & Ad. News at 1943, 2085-86; H.R. Rep. No. 213, 89th Cong., 1st Sess. at 127-29 (1965). (Though in 1965 Congress was concerned specifically with the need for alternative care for aged mental patients, the committee reports fairly imply that Congress saw a need for more alternative care for mental patients in general.) Congress accordingly made the states adopt plans for alternative care of mental patients as a condition of funding for care to the aged in IMDs. 1965 Act, sec. 121, § 1902(a)(20), 79 Stat. at 347 (codified as amended at 42 U.S.C. § 1396(a)(20) (1976)); Statement of Sen. Long, 110 Cong. Rec. 21348 (1964). Therefore, Congress in 1965 had good reason to limit the IMD exclusion to "mental hospitals."

Just what did Congress mean by a "mental hospital"? Though Congress spoke of the long-term care given in hospitals for tuberculosis and mental illness, a facility apparently did not have to give long-term care in order to be an IMD. As mentioned above, the 1965 Act did not exclude IMD coverage for individuals aged 65 and over. In urging IMD coverage for such individuals, supporters of the bill interpreted the IMD exclusion as prohibiting payments for care even in hospitals which gave primarily short-term care. Statement of Sen. Ribicoff,¹⁶ 111 Cong. Rec. 15801, 15805 (1965) (amendment was needed to remove the limitation on treatment for aged recipients "in mental or tuberculosis hospitals"; such limitation was reasonable only "based on the [outdated] assessment that the patients required long-term institutional care—which was a State responsibility"); see Statement of Sen. Carlson, 110 Cong. Rec. 21349 (1964) (asserting both that "[w]e have made great strides in the field of mental disease and in the field of tuberculosis" and that "we still prohibit long-term care and/or care in institutions specializing in these two diseases").

So long-term care was not a defining criterion of an IMD. Neither apparently was any particular level of psychiatric care. As late as 1965, Congress observed that many mental hospitals provided primarily custodial care rather than treatment leading to cure. See S. Rep. No. 404, Part I, 89th Cong., 1st Sess. 147, reprinted in 1965 U.S. Code Cong. & Ad. News 1943, 2086 ("there is great need for increased professional [mental health] services in hospitals"), and *id.* at 146, 1965 U.S. Code Cong. & Ad. News at 2086 (stressing need for states to move ahead with comprehensive mental health plans as contemplated in the 1963 Act, in conjunction with H.R. Rep. No. 694, 88th Cong., 1st Sess., reprinted in 1963 U.S. Code Cong. & Ad. News 1054, 1064 (considering the 1963 Act) ("Only a small percentage of the [state mental] institutions can be said to be therapeutic and not merely custodial.")). Therefore, by "mental hospital" Congress did not have in mind any level of psychiatric care.

¹⁶ Senator Ribicoff was a leading sponsor of the 1965 legislation, and a former HEW Secretary. Plaintiff's Brief at 13-14.

Though a "mental hospital" did not, in Congress' contemplation, have to provide long-term care or any particular level of psychiatric care, it did have to provide total care.¹⁷ The term "hospital" connotes total care. Further, Congress' image of a state mental hospital was an institution which completely controlled the lives of its patients. H.R. Rep. No. 694, 88th Cong., 1st Sess., *reprinted in* 1963 U.S. Code Cong. & Ad. News 1054, 1064 (the state mental hospital, the treatment for most mentally ill patients, is the modern means for society to isolate, confine, and reject the mentally ill). Further, in 1971, when Congress added ICF coverage to Title XIX,¹⁸ Congress contrasted the level of care of an ICF with that of a hospital. An ICF was defined as providing care beyond room and board but below that of a hospital or skilled nursing home. 1971 Act, sec. 4, § 1905, 85 Stat. at 809 (codified as amended at 42 U.S.C. § 1396d(c) (Supp. IV 1980)), quoted *supra* p. 6). ICF care coverage was intended for persons who "in the absence of intermediate care would require placement in a skilled nursing home or mental hospital." Statement of Senate Finance Committee, printed in Statement of Sen. Long, 117 Cong. Rec. 44721 (1971).¹⁹

¹⁷ The phrase "total care" is defined in note 9 *supra*.

¹⁸ Congress had previously enacted ICF coverage for care for the aged, blind, and disabled under Title XI in 1967. 1967 Act, sec. 250(a), § 1121, 81 Stat. at 920.

¹⁹ Similar statements accompanied earlier proposals to include ICF coverage under Medicaid. Senate Comm. on Finance, 92d Cong., 1st Sess., Material Related to H.R. 1—Medicare and Medicaid Amendments 48 (Comm. Print 1971); Statement of Sen. Long, 116 Cong. Rec. 41798, 41804 (1970).

As well as indicating that by "mental hospital" Congress meant a total care institution, this legislative history from 1970-1971 suggests on its own that an "IMD" cannot be defined, as HHS urges, as an institution primarily for mental patients. Indeed, since Congress intended ICF coverage for patients who otherwise "would require placement in a . . . mental hospital," it is unlikely then that Congress intended to exclude coverage in a facility which existed "primarily" for such persons.

So far, it appears that Congress meant the IMD exclusion to apply only to facilities providing total care to mental patients.²⁰ This interpretation answers the argument put forth by HHS that a state might transfer mental patients in large numbers from hospitals to ICFs such as Middletown Haven in order to increase federal cost sharing. Since ICFs provide less than total care, Congress did not intend to exclude coverage of their patients. Such transfers therefore would not violate Congress' purpose. Of course, only patients who do not need total care should be transferred. But the Secretary can mandate standards to that effect, 42 U.S.C. § 1396d(c) (Supp. IV 1981), and the state plans are already required to ensure that ICF patients are receiving enough care, 42 U.S.C. § 1396a(31) (1976).

2. Various Sections Explained

Legislative history, by illuminating two of the three suggestive statutory sections discussed *supra* pp. 9-11, further supports the interpretation of "IMD" as, at the least, a facility providing total care to mental patients. In the case of section 1396d(a), legislative history weakens arguments by HHS that an IMD cannot be just a mental hospital. In the case of section 1396a, legislative history strengthens and clarifies the inference that "community mental health centers" cannot be IMDs.

Section 1396d(a). In 1965, Congress covered inpatient hospital services and skilled nursing facility services by enacting parts (1) and (4) respectively of section 1396d(a). In 1971, Congress covered ICF services by enacting part (15) of this

²⁰ As just explained, a "mental hospital" need not provide long-term care, and it need not provide any particular level of psychiatric care; but it must provide total patient care. There may be further restrictions on what a "mental hospital" can be. A facility may need to have "enough" mental patients, in some sense, in order to be a "mental hospital." Further, it is possible that facilities with certain organizational structures cannot be IMDs. See, e.g., *infra* pp. 25-27 ("community mental health centers" are not IMDs). For the case at bar, it is not necessary to determine what restrictions there are on an IMD, beyond that it provide total care.

section. All three parts explicitly exclude coverage for "services in an institution for tuberculosis or mental diseases." HHS infers that, since ICFs and skilled nursing facilities may be IMDs, an "IMD" cannot be restricted to a mental hospital. However, these sections, simply read, speak to the case in which an inpatient hospital facility, skilled nursing facility, or intermediate care facility *may also happen to be* an IMD.²¹ At least in the case of an ICF which is also an IMD, one facility would be giving *two different kinds of care* (total care and non-total care). For such a facility, *none* of the care would be covered.²²

HHS argues that such a reading is strained, because it would require that "Congress' references to *e.g.*, intermediate care facility services [excluded as being provided in IMDs], is to a particular level of services provided *outside* a facility created to provide such service." Defendant's Brief at 11. However, the ICF services in question would not be provided outside an ICF; rather, they would be provided inside a facility that is both an ICF and an IMD.

Further, some legislative history of the 1971 Act supports this reading. Senator Bellmon explained that a skilled nursing facility might provide not only skilled nursing care but also intermediate (ICF) care. In that case, the ICF care given would qualify for reimbursement even though it was given in a skilled nursing facility. Statement of Sen. Bellmon, 117 Cong. Rec. 44720, 44721 (1971). Thus, at least in 1971, Congress

²¹ The statute expressly allows that one facility may be both an ICF and a hospital. "The term 'intermediate care facility' also includes any skilled nursing facility or hospital which meets [various requirements of quality and patient protection]." 42 U.S.C. § 1396d(c) (Supp. IV 1980).

²² HHS cites H.R. Rep. No. 231, 92d Cong., 2d Sess., reprinted in 1972 U.S. Code Cong. & Ad. News at 4989, 5097-98, for the proposition that "ICF care" cannot refer to care within a nursing home, and thus by analogy cannot refer to care within an IMD. Defendant's Brief at 13. However, the report cited simply warns against substandard nursing homes being passed off as ICFs, and notes that ICFs are not for patients who need full nursing care. The report nowhere implies that one facility may not give both ICF and nursing home care. In fact, Congress explicitly contemplated such an arrangement, Statement of Sen. Bellmon, 117 Cong. Rec. 44721 (1971), and the statute itself contemplates such an arrangement, *supra* note 21.

was considering the technical problem of coverage in one facility which gave two kinds of care. Therefore, it seems reasonable that in 1965 Congress took care to say that inpatient hospital services and skilled nursing facility services that happened to take place in a facility that was also an IMD were *not* covered, and that in 1971 Congress said further that ICF services that happened to take place in a facility that was also an IMD were *not* covered.

HHS points also to section 1396d(a)(14), which explicitly covers "inpatient hospital services, skilled nursing facility services, and intermediate care facility services for individuals 65 years of age or over in an institution for tuberculosis or mental diseases." Again, it seems to HHS that this section reads unnaturally if an IMD is a mental hospital. Defendant's Brief at 12. However, since the section simply restores to those over 65 the coverage in IMDs for three particular services which was generally excluded in the sections discussed above, the section does not seem at all unnatural.²³

Congress enacted this section in the 1972 Act, sec. 297, 86 Stat. at 1459-60. Because inpatient hospital services, skilled nursing facility services, and intermediate care facility services were already covered by sections 1396d(a)(1), (4), (15), and the IMD exclusion in those sections and in section 1396d(a)(B) applied only to those under 65, section 1396d(a)(14) was not strictly necessary. It was added rather for clarity, especially to make clear that the unusual situation of an IMD giving ICF services for someone 65 or over was covered. S. Rep. No. 1230, 92d Cong., 2d Sess. 321 (1972).

²³ HHS argues that, if an IMD were a mental hospital, then the term "hospital" would be superfluous, and Congress would instead have referred to "simply 'all services, including SNF and ICF services, provided in an IMD.'" Defendant's Brief at 12. However, the wording which Congress chose seems, if anything, simpler than HHS' proposed wording. Congress' wording also reads more easily because it better tracks the rest of the statute.

HHS points to a conference report which describes the provision as providing that "when a State chooses to cover individuals age 65 and over in institutions for . . . mental diseases it must cover such care in intermediate care facilities as well as in hospitals and skilled nursing homes." H.R. Rep. No. 1605 (Conference Report), 92d Cong., 2d Sess. 65, *reprinted in* 1972 U.S. Code Cong. & Ad. News 5370, 5397. This report seems to consider that institutions for mental disease may as a regular matter be hospitals, nursing homes, and intermediate care facilities. HHS thus argues that an IMD cannot be limited to a mental hospital. Defendant's Brief at 13. However, this conference report is confused. The report improperly states that the provision *requires* coverage of ICF services in IMDs if a state covers hospital and skilled nursing home services in IMDs, when such coverage is optional, *see* 42 U.S.C. § 1396a(13) (1976 & Supp. IV 1980). Further, though the amendment only applies to Medicaid, the report titles it as applying to "Medicare." The conference report considered this amendment very briefly, and it dealt with many amendments, all in a year-end rush, Plaintiff's Reply Brief at 11 n.3. The report is thus not persuasive on this technical point.

Section 1396a. Section 1396a(21) gives "community mental health centers" as an example of an alternative to "public institutions for mental diseases." It was noted, *supra* p. 11, that this language, while suggesting that Middletown Haven is not an IMD, is not conclusive for two reasons. First, "community mental health center" is undefined. Second, Congress in this section may have contemplated community mental health centers as privately run; in that case, they would be alternatives to "public institutions for mental disease" simply because they were private, not because they were not institutions for mental disease. Legislative history speaks to both of these questions, establishing that a community health center is not an IMD and clarifying what a community mental health center is.

A good source of what Congress meant by "community mental health centers" in 1965 is the Community Mental

Health Centers Act of 1963.²⁴ In the 1963 Act, Congress envisioned community mental centers as follows:

The patient services included in such a center would include an emergency psychiatric unit, inpatient services, outpatient services, day and night care, foster home care, rehabilitation programs, and general diagnostic and evaluation services. In addition, the center would offer consultative services to other community agencies and organizations such as information programs in schools and through other public and private agencies.

The community mental health center would build on and be a part of the existing resources and programs of the community—public and private—rather than be isolated from them. For example, the psychiatric ward of a general hospital would be the major focus of the center in many communities. Existing outpatient mental health clinics might also form the nucleus of a center. Each community would have a major voice in determining the basic pattern of services to be offered through its own mental health center.

H.R. Rep. No. 694, 88th Cong., 1st Sess., *reprinted in* 1963 U.S. Code Cong. & Ad. News 1054, 1065-66. Since community mental health centers could "build on and be a part of . . . public and private" resources, Congress apparently envisioned them as quite free to be either public or private. Thus, in section 1396a(21) Congress did imply that community mental

²⁴ Indeed, the 1963 Act's program for community mental health centers was still very much on Congress' mind as it considered the 1965 Act. In fact, Congress saw sections 1396a(20)-(21) as helping to carry out the 1963 Act's program. S. Rep. No. 404, Part I, 89th Cong., 1st Sess. 146, *reprinted in* 1965 U.S. Code Cong. & Ad. News 1943, 2086 (stressing need for states to move ahead with comprehensive mental health plans as contemplated in the 1963 Act).

health centers (which may indeed be public) are not "institutions for mental disease."²⁵

The quotation above characterizes community mental health centers in terms of the range of services provided, the community-based resources used, and the community's voice in the center's control. Section 1396a(21) strongly suggests that *an establishment meeting this description is not an IMD*. This italicized proposition could be considered largely as an example of the more general proposition that an IMD must provide total care. Indeed, of the various services listed for a community mental health center to provide, only one, "inpatient services," involves total care.²⁶ This proposition does however suggest other limits on what an IMD can be. For this case, we need not discuss these limits.²⁷ At any rate, the italicized proposition above cuts directly against HHS' position that any institution maintained primarily for mental patients is an IMD.

D. Conclusion

At first glance, the term "institution for mental diseases" (IMD) is quite uncertain in meaning. The legislative history behind the enactment in 1965 of the IMD exclusion in section 1396d(a)(B) indicates that an IMD is a "mental hospital." Further legislative history reveals that a "mental hospital" means, at the least, a facility which provides total care to mental patients.

²⁵ Further, the legislative history of the 1965 Act itself supports the view that community health centers were an alternative to public and private institutions for mental disease. The Senate committee report mentioned community mental health centers as an alternative to "mental hospitals," S. Rep. No. 404, Part I, 89th Cong., 1st Sess. 146, reprinted in 1965 U.S. Code Cong. & Ad. News 1943, 2086, which in turn the committee was using as a synonym for "institutions for mental diseases," see *id.* at 144-47, 1965 U.S. Code Cong. & Ad. News at 2084-87.

²⁶ If a community mental health center did offer some services in a mental hospital setting, those services would, notwithstanding section 1396a(21), be excluded from coverage as occurring in an IMD. However, other services offered by the community mental health center need not be therefore tainted. Section 1396d(a)(15), which provides coverage for "intermediate care facility services (other than such services in an institution for mental diseases)," might still cover ICF services given by the community mental health center if they were given in a physically separate facility. Cf. § 1396d(c) (considering the character of a "distinct part" of an institution).

²⁷ See *supra* note 20.

Other sections of the Medicaid statute, viewed together with legislative history, support this interpretation of "IMD." Section 1396d(c), by suggesting equal treatment of mental and physical conditions, favors this interpretation because it discriminates less effectively against mental patients than does an interpretation, as proposed by HHS, based solely on whether the institution is maintained primarily for mental patients. Section 1396a(20) implies that a "community mental health center" is not an IMD. Section 1396d(a), parts (1), (4) and (15), which exclude care in IMDs from certain covered care, and part (14), which specifically includes these same types of care in IMDs for persons aged 65 or over, do not read unnaturally with this interpretation of "IMD."

Therefore, I hold that an IMD is a mental hospital, which in turn means, at the least, a facility which provides total care to mental patients.

VI. DEFERENCE TO HHS

HHS asserts that its regulations interpreting the statute deserve deference.²⁸ The parties argue back and forth about whether HHS' regulations and practice have been clear and longstanding. That argument need not be considered, for even a clear, longstanding agency interpretation would not deserve deference here. The reason is that the statutory construction at issue involves not technical details but the statute's broad purpose. While agencies are expert at the former, courts are expert at the latter.²⁹

²⁸ HHS cites *Schweiker v. Gray Panthers*, 453 U.S. 34, 44 (1981). In that case, Congress had "explicitly delegated to the Secretary broad authority to promulgate regulations defining eligibility requirements for Medicaid." *Id.* at 43. No such explicit delegation exists in the case at bar.

²⁹ HHS also argues that Congress, by amending the Medicaid provisions without further defining "IMD," silently approved HHS' definition. Defendant's Reply Brief at 5-6. This argument depends not on deference to HHS but on inferring Congress' intent from silence. The force of this argument depends on what HHS did (see, e.g., Defendant's Brief at 19, arguing that regulations supporting HHS' position have been in effect since 1966) and how Congress reacted (see, e.g., *supra* note 19, implying that Congress in 1971 did not approve HHS' position). In any event, this argument, being merely one based on silence, would not overcome the clear indications discussed above that Congress had a different definition in mind.

Judge Friendly discussed the issue of deference to administrative interpretations of statutes in *Pittson Stevedoring Corp. v. Dellaventura*, 544 F.2d 35 (2d Cir. 1976), *aff'd sub nom. Northeast Marine Terminal Co. v. Caputo*, 432 U.S. 249 (1977). At issue was whether the 1972 amendments to the Longshoremen's and Harbor Workers' Compensation Act could cover workers while engaged in stuffing and stripping containers on shore. In affirming the agency's holding of coverage, the court relied on its own statutory interpretation rather than on deference to the agency. *Id.* at 51-56. In declining to rely on deference to the agency, Judge Friendly noted that there are two conflicting lines of Supreme Court authority regarding deference to agencies on issues of statutory interpretation. One line "support[s] the view that great deference must be given to the decisions of an administrative agency applying a statute to the facts and that such decisions can be reversed only if without rational basis." The other line "sanction[s] free substitution of judicial for administrative judgment when the question involves the meaning of a statutory term." *Id.* at 49. From this second line, Judge Friendly singled out *Morton v. Ruiz*, 415 U.S. 199, 237 (1974), in which the Supreme Court held that "In order for an agency interpretation to be granted deference, it must be consistent with the congressional purpose." Judge Friendly noted that this holding "very nearly eliminates the 'deference' principle as regards statutory construction altogether since if the agency's determination is found by a court to be consistent with the congressional purpose, it presumably would be affirmed on that ground without any need for deference." 544 F.2d at 49.

In fact, even the line of Supreme Court cases supporting deference is perfectly consistent with independent judicial determination of a statute's broad purpose. One case in this line is *NLRB v. Hearst Publications, Inc.*, 322 U.S. 111 (1944). At issue there was whether newsboys were "employees" under the National Labor Relations Act. Without even pausing to justify doing so, the Court interpreted the purpose of the Act. The Act aimed to "bring industrial peace by substituting, so far as its power could reach, the rights of workers to self-

organization and collective bargaining for the industrial strife which prevails where these rights are not effectively established." *Id.* at 125. The Act tried to correct "the inability of individual workers to bargain successfully for improvements in their 'wages, hours, or other working conditions' with employers who are 'organized in the corporate or other forms of ownership association.'" *Id.* at 126. The Court concluded that an economically inferior party, having need of the Act's protection, could be an employee for the purposes of the Act even if at common law he would be instead an independent contractor. *Id.* at 126-29. The Court so interpreted the statute with no mention of the NLRB. Only then did the Court defer to the Board's finding, based on the details of the work situation involved, that certain newsboys were employees. The Board's discretion was allowed only within the framework of the Court's interpretation. "Determination of 'where all the conditions of the relation require protection' involves inquiries for the Board charged with this duty." *Id.* at 130.

Another case in this line, *Gray v. Powell*, 314 U.S. 402 (1941), contains a similar analysis. The Bituminous Coal Act regulated coal marketing but exempted coal consumed by the producer. *Id.* at 410-11. At issue was the scope of this exemption. The Court first determined on its own that the Act's purpose required looking behind nominal ownership to real economic identity, and then deferred to the agency on the details of how to determine such economic identity. The Court held:

The separation of production and consumption is complete when a buyer obtains supplies from a seller totally free from buyer connection. Their identity is undoubted when the consumer extracts coal from its own land with its own employees. Between the two extremes are the innumerable variations that bring the arrangements closer to one pole or the other of the range between exemption and inclusion. To determine upon which side of the median line the particular instance falls

calls for the expert, experienced judgment of those familiar with the industry.

Id. at 413.³⁰

This distinction between interpreting a statute's broad purpose on the one hand, and effecting technical classifications pursuant to that purpose on the other, finds strong support from Professor Kenneth Culp Davis. According to Professor Davis, underneath the complex rhetoric, courts in the main act as follows:

In absence of a particular statute otherwise providing, courts avoid substitution of judgment for that of the agencies on all questions except the kind of questions of law about which courts are generally better qualified than agencies

K. Davis, *Administrative Law Treatise* ¶ 29.00-1 at 520 (Supp. 1982) (emphasis in original).³¹ Generally, courts better than agencies can determine the broad purpose behind a statute. Courts are skilled in examining statutory language and legislative history to determine Congress' purpose. Courts are also free of a narrow view which may taint agencies. Further, technical agency expertise is of little value in ascertaining the statute's broad purpose. On the other hand, determining the best technical implementation of policy, including how to categorize borderline cases, is generally done better by agencies with technical expertise. The same point runs through most of the commentaries excerpted in W. Gellhorn, C. Byse & P. Strauss, *Administrative Law—Cases and Comments* 309-18 (7th ed. 1979).

In the case at bar, the basic issue discussed above has been one of broad statutory construction: what was Congress' purpose behind the IMD exclusion? By examining statutory language and legislative history, I found that Congress meant to

³⁰ *NLRB v. Hearst and Gray v. Powell* are analyzed in this way in Nathanson, *Administrative Discretion in the Interpretation of Statutes*, 3 Vand. L. Rev. 470, 472-75 (1950).

³¹ Professor Davis is discussing "Scope of Review of Informal Action Including Rulemaking." The vast bulk of agency action, including the regulations at issue here, is "informal" as that word is technically used.

exclude mental hospitals, meaning, at the least, facilities which provide total care to mental patients. Fine determinations of what constitutes total care are proper subjects for administrative expertise, but not the basic determination above.

VII. CONCLUSION

The IMD exclusion in 42 U.S.C. § 1316d(a) (part of the Medicare program, Title XIX of the Social Security Act) excludes only care in mental hospitals, meaning care in facilities which, at the least, provide total care to mental patients. This interpretation is based on this court's independent review of the statute's language and legislative history, without deference to HHS' contrary interpretation, even though HHS' interpretation may have been longstanding.

Accordingly, the Secretary's decision that Middletown Haven Rest Home is an IMD was based on improper factors. Specifically, the Secretary did not determine that Middletown Haven provided total care to mental patients. Accordingly, the Secretary's decision was "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law" within the meaning of APA section 706(2)(A), 5 U.S.C. § 706(2)(A) (1976). *Citizens to Preserve Overton Park v. Volpe*, 401 U.S. 402, 416, 420 (1971). The Secretary's decision is accordingly reversed and remanded to HHS.

As HHS' determination has been reversed, HHS has now no claim against Connecticut based on the funds which HHS had disallowed (though a claim may arise in the future if HHS disallows the funds on proper grounds). This court trusts that HHS accordingly will assert no setoff, and will promptly restore any setoff already taken. An injunction is therefore unnecessary.

SO ORDERED.

Dated at Hartford, Connecticut, this 17th day of February, 1983.

M. JOSEPH BLUMENFELD
Senior United States District Judge

APPENDIX D**DEPARTMENTAL GRANT APPEALS BOARD****Department of Health and Human Services**

Subject: Joint Consideration: Date: November 30, 1981

"Institutions for Mental Diseases"

Docket Nos. 79-52-MN-HC
 79-89-MN-HC
 80-44-IL-HC
 80-150-CT-HC
 80-184-CA-HC

Decision No. 231

DECISION

The Board jointly considered five appeals by four different States (Minnesota, Illinois, Connecticut, and California), raising common issues of law and some common issues of fact. Each appeal was from a determination by the Health Care Financing Administration (Agency), disallowing Federal financial participation (FFP) claimed by a State under Title XIX (Medicaid) of the Social Security Act for services provided in a private facility certified by that State as a skilled nursing facility (SNF) or intermediate care facility (ICF). The Agency determined that the facilities were "institutions for mental diseases" and, therefore, FFP was not available under Medicaid for services provided by the facilities to individuals under age 65.

Our decision is based on the States' applications for review; the Agency's responses to the separate appeals; pre-hearing briefing submitted by the State of Connecticut; the transcript of a hearing held before the full Panel on April 22 and 23, 1981, involving all four States; exhibits submitted at the hearing; the Agency's consolidated brief, filed after the hearing; and the States' reply briefs. Although no party objected to joint consideration and, in fact, each State chose to rely on oral

presentations by other States on various issues, each State was given a full opportunity to present its individual case.

Because of the complexity of the issues raised, and the number of parties and facilities involved, we have first briefly summarized our decision (Section I). We then present a more detailed analysis of the parties' arguments, divided into three major sections: issues related to the relevant statutory provisions and their legislative history (Section II); issues related to pertinent regulations (Section III); and issues related to certain Agency "Criteria" for applying the regulations (Section IV). Finally, we discuss the factual issues raised by specific States (Section V).

I. Summary of Decision

Under Title XIX of the Social Security Act (Act), FFP is not available for certain services provided to any person under 65 who is a patient in an "institution for mental diseases" (IMD). The Act does not define this term. Agency regulations provide that an IMD is an institution "primarily engaged in providing diagnosis, treatment or care of persons with mental diseases," and that whether a particular facility is an IMD is determined by its "overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases." The Agency used unpublished supplementary criteria in applying the regulation.

Briefly, the Agency determined that high percentages of the patients in the SNFs and ICFs had mental diseases; that most of the facilities held themselves out as caring for the mentally ill; that some of the facilities had special programs designed specifically for the mentally ill; and that each facility had other characteristics of an IMD under the regulations.

The States did not challenge the validity of the Agency regulations. Rather, the States argued based on their reading of the Act and its history, and on their reading of the regulations, that the IMD exclusion should be interpreted to cover only the traditional mental hospital or its equivalent, not the SNFs and ICFs here. The States challenged the use of the Agency's

supplementary criteria, arguing that the criteria were not properly published and, in any event, are flawed and were erroneously applied. In particular, the States attacked the Agency approach of counting patients with mental disorders in the facilities.

Our determinations, discussed in detail below, are as follows:

- The Agency's regulations reflect a reasonable interpretation of the Act and its legislative history, and were clear enough to put the States on notice that facilities such as these SNFs and ICFs are IMDs.
- There is persuasive evidence, by any reasonable standard, to show that the "overall character" of the facilities in question was that of institutions established and maintained primarily for the care and treatment of persons with mental diseases.
- Lack of publication of the criteria does not provide a basis for reversing the disallowances here, since these facilities were IMDs under any reasonable reading of the regulations.
- Although some of the Agency's findings developed through using the criteria carry less weight or represent some inconsistency in applying the criteria, these defects do not invalidate the Agency's findings as a whole.

Based on these findings and conclusions, we have upheld the disallowances.

In doing so, we are mindful that the dispute is, in large part, a consequence of the absence of explicit Congressional guidance in the face of changing circumstances in the care of the mentally ill. Neither side is supported definitively by the Act or its legislative history, and there are countervailing policy considerations involved: the disincentive that these disallowances might provide for the principle of deinstitutionalization of the mentally ill, and the concern of the Agency that States might inappropriately move patients out of mental hospitals into SNFs or ICFs to maximize FFP. But whether or

not the law or the regulations should be changed are policy questions beyond the authority of this Board. Our decision essentially is that the Agency's rules, reflecting a reasonable interpretation of the statute, were fairly applied here and that there is substantial evidence in the record to support the conclusion that these facilities were IMDs.

II. The Statute and Legislative History

The major issue raised by the States is whether the statutory language, read in light of the legislative history of the IMD exclusion, compels a reading of the statute and regulations under which the exclusion applies only to institutions which are similar to, or the functional equivalent of, mental hospitals. Stated differently, the issue is whether the Agency application of the statute and regulations to the private, free-standing SNFs and ICFs here is consistent with legislative intent. For the reasons discussed below, we conclude that the Agency interpretation is supported by the language of the statute and that the legislative history does not compel a different reading.

Our discussion of this issue is divided into three parts: the history of development of the IMD exclusion and relevant provisions from Title XIX; a statement of the parties' arguments on this issue; and our analysis of the arguments.

A. Development of the Statutory Exclusion

The Social Security Act Amendments of 1950, Pub. L. 81-734, contained the original IMD exclusion. Those amendments defined "old age assistance," under Title I of the Act, to include payments to residents of most public medical institutions but to exclude "payments to or care in behalf of . . . any individual (a) who is a patient in an institution for tuberculosis or mental diseases, or (b) who has been diagnosed as having tuberculosis or psychosis and is a patient in a medical institution as a result thereof." Section 6 of the Act.¹

¹ The relevant House Report states: "Your committee does not favor Federal participation in assistance to persons residing in *public or private* institutions for mental illness . . . , since the States have generally provided for medical care of such cases." H.R. Rep. 1300, 81st. Cong., 1st Sess. 42 (1949). (Emphasis added.)

When "medical assistance" for the aged was added in 1960, Pub. L. 86-778, that term was similarly defined to exclude payments with respect to long-term "care or services for . . . any individual who is a patient in an institution for . . . mental diseases" Section 6(b).

The Social Security Act Amendments of 1965, Pub. L. 89-97, removed prohibitions on funding for the mentally ill in a general hospital and provided for the first time for medical assistance on behalf of individuals 65 years of age or older who were patients in IMDs. To receive Federal funding for such assistance, however, States had to have programs which met certain standards. Conditions included "the development of alternate plans of care . . . for recipients 65 years of age or older who would otherwise need care in such institutions" and "assurance of immediate readmittance to institutions where needed for individuals under alternate plans of care." If a State plan included such assistance to patients in public institutions for mental diseases, the State had to show that it was making "satisfactory progress toward developing and implementing a comprehensive mental health program, including provision for utilization of community mental health centers, nursing homes, and other alternatives to care in public [IMDs]."²

The House Report on the 1965 Amendments referred to "payments to, or for, patients in mental hospitals" H.R. Rep. No. 213, 98th Cong., 1st Sess. 19 (1965). The exclusion was explained (at 126) as relating to patients in public or private mental hospitals since "long-term care in such

² These provisions were originally proposed as amendments to Titles I (Old-Age Assistance and Medical Assistance for the Aged) and XVI of the Act. Identical provisions were incorporated into Title XIX at Sections 1902(a)(20) and (21). The provisions were promoted on the Senate floor by Senator Carlson who spoke of "great strides in the field of mental disease," stating that he was "convinced that the time has come that these diseases should no longer be set apart from others" He also referred to the need for greater flexibility in care of the aged than in other age groups, since it is difficult to determine whether an elderly person is mentally ill or merely senile, and "it may be appropriate for him at one time to be in a mental institution and at another to be in a nursing home, his own home, or in some other arrangement." 110 Cong. Rec. 21349 (1964).

hospitals had generally been accepted as a responsibility of the States." The term "hospital" was used in the report to explain removal of the exclusion and "nursing homes" were referred to as an alternative to care in such hospitals.³

In Title XIX of the Act, also enacted in 1965, the exclusion appears in the general definition of "medical assistance" for which FFP is available, as well as in conjunction with various levels of services. Section 1905(a) currently defines "medical assistance" as—

payment of part or all of the cost of the following care and services . . .

- (1) inpatient hospital services (other than services in an institution for tuberculosis or mental diseases);
• • •
- (4)(A) skilled nursing facility services (other than services in an institution for tuberculosis or mental diseases) . . . ;
• • •
- (14) inpatient hospital services, skilled nursing facility services, and intermediate care facility services for individuals 65 years of age or over in an institution for tuberculosis or mental diseases;
- (15) intermediate care facility services (other than such services in an institution for tuberculosis or mental diseases) . . . ;
• • •

except as otherwise provided in paragraph (16), such term does not include—

- (A) any such payments with respect to care or services for any individual who is an inmate of a public

³ Similar language appears in the Senate Report. S.Rep. No. 404, Part I, 89th Cong., 1st Sess. 144-47 (1965). See also, Statement of Senator Ribicoff, 111 Cong. Rec. 15801 (1965).

institution (except as a patient in a medical institution); or

- (B) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in any institution for tuberculosis or mental diseases.

For purposes of Title XIX, the term "intermediate care facility" is defined as—

an institution which (1) is licensed under State law to provide, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities Section 1905(c).⁴

The provisions for coverage of ICF services were added by the Social Security Act Amendments of 1972. These Amendments also added paragraph (16) to Section 1905(a), including as "medical assistance" under certain conditions "inpatient psychiatric hospital services for individuals under 21" The conditions for coverage included that the institution in which the services were provided be "accredited as a psychiatric hospital by the Joint Commission on Accreditation of Hospitals" and that the services involve "active treatment" which could reasonably be expected to improve the patient's condition. Section 1905(h)(1).⁵

⁴ This section further provides, "With respect to services furnished to individuals under age 65, the term 'intermediate care facility' shall not include, except as provided in subsection (d), any public institution or distinct part thereof for mental diseases or defects." Subsection (d) provides that, under certain conditions, ICF services may include services in "a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions"

⁵ A Finance Committee amendment which would have also authorized funding of demonstration projects to determine the "potential benefits of extending medicaid coverage to mentally ill persons between the ages of 21 and 65," S.Rep. No. 1230, 92d Cong., 2d Sess. 57 (1972), was dropped in conference, H.R.Rep. No. 65, 92d Cong., 2d Sess. 65 (1972).

B. The Parties' Arguments on Legislative Intent

The States' position is that "Congress intended the term 'institution for mental diseases' to apply only to mental hospitals, which were the facilities traditionally used by states to care for the mentally ill." Brief of the State of Connecticut (CT Br.), p. 3.⁶ Under the States' interpretation SNF or ICF services would be excluded only if provided in a State mental hospital or the functional equivalent.

The Agency position is that SNF or ICF services are excluded if they are provided in any institution which meets the regulatory definition. Such an institution could be a private facility and it need not be part of or on the grounds of a mental hospital; the basic requirement is that the institution's overall character must be that of a facility established and maintained primarily for individuals with mental diseases.

For their position, the States rely primarily on the references to "mental hospitals" in the legislative history cited above and on several court opinions which refer to the exclusion. The States cite to language in the Supreme Court case of *Schweiker v. Wilson*, 450 U.S. 221 (1980),⁷ and to similar statements in two other cases,⁸ in support of their view that "it was the large

⁶ See also, Post-Hearing Reply Brief of State of California (CA Reply Br.), p. 2 (relating the exclusion to "the traditional state mental hospital or the functional equivalent thereof").

⁷ In that case, the Court related the IMD exclusion to Congress' assumption that the care of persons in public mental institutions was properly a responsibility of the States, citing for this conclusion the legislative history reference to "long-term care in such hospitals . . ." 450 U.S. at 237, n. 19. The States also rely on the following statement in the dissent in *Schweiker*: "The residual exclusion of large state institutions for the mentally ill from federal financial assistance rests on two related principles: States traditionally have assumed the burdens of administering this form of care, and the federal government has long distrusted the economic and therapeutic efficiency of large mental institutions." See S. Rep. No. 404, 98th Cong., 1st Sess., 20 (1965), reprinted in 1965 U.S. Code Cong. & Admin. News 1943, 2084." 450 U.S. at 242.

⁸ *Legion v. Richardson*, 354 F. Supp. 456 (S.D.N.Y.), *aff'd sub nom.*, *Legion v. Weinberger*, 414 U.S. 1058 (1973), and *Kantrowitz v. Weinberger*, 388 F. Supp. 1127, 1130 (D.D.C. 1974), *aff'd* 530 F.2d 1034 (D.C.Cir.), *cert. denied*, 429 U.S. 819 (1976).

state-financed mental hospitals, which provided primarily custodial care, that Congress meant to exclude," not SNFs and ICFs. CT Br., pp. 19-20. The States argue that SNFs and ICFs were developed as alternatives to care in traditional institutions, as shown by the statutory provisions and legislative history associated with the 1965 Amendments. Since use of nursing homes was encouraged by Congress as part of the process of "deinstitutionalization," the States contend, these SNFs and ICFs cannot themselves be the type of institutions which Congress refused to fund.

The Agency responds that "although the statute does not specifically state that a SNF or an ICF can be an IMD, such an interpretation is the only reasonable one . . ." Consolidated Response of the Health Care Financing Administration to the States' Applications for Review (Cons. Br.), p. 31. The Agency relies primarily on the language of the Act, particularly Section 1905(a). The scheme of that section, as a whole, the Agency argues, supports the position that hospitals do not occupy some special status. Cons. Br., p. 36. Since that section lists hospital services separately from SNF and ICF services, and excludes each type of service in an IMD, the section must be read so that an SNF or ICF can be an IMD, the Agency contends.

Citing Section 1905(a)(14), the Agency argues:

Acceptance of the States' argument that an IMD can only be a hospital, in effect, makes superfluous the term "hospital" in this provision since it presumably was the same as, and was already included, within the term IMD. If this was the intent, the provision would have stated simply "all services, including SNF and ICF services provided in an IMD." It was not so drafted and as a result the terms hospital, SNF, and ICF services must be interpreted consistently to permit any of these institutions to be IMDs. Cons. Br., p. 33.

The States counter that the term "hospital" in the legislative history was not intended to refer merely to a level of care (acute care), like the term "hospital" in the Act itself. Rather, the States argue, Congress used the term in the legislative

history to refer to "a 'total institution' setting, that is, a place where all the patients' needs were met by the facility." CA Reply Br., pp. 6-7; see also CT Br., p. 20, n.2. Since this kind of institution might offer different levels of care, the States argue, Congress needed to refer to all three levels to effect a complete exclusion of all services provided by the institution. See, e.g., CT Br., p. 20, n. 1; CT Reply Br., p. 4. The States argue that, since section 1905(a) refers to services *in* an IMD, the section can reasonably be read to mean merely that no level of services can be provided to persons under 65 in a mental hospital. CA Reply Br., p. 8.

The Agency responds that the States' interpretation is not logical because, under it, an institution could never be an IMD, "even if the institution provided solely psychiatric services at a SNF level of care to 100% of its patients. . . ." Cons. Br., p. 37.

An additional State argument, related solely to ICFs, is based primarily on the statutory definition of an ICF at Section 1905(c). This section refers to ICFs providing "care and services to individuals who . . . because of their *mental* or physical *condition* require care and services" (Emphasis added.) The States argue, "It would be wholly inconsistent with this explicit statutory language to remove Medicaid coverage for an ICF simply because some percentage of the residents have been placed there because of a mental condition." CT Reply Br., p. 18. The States also point to legislative history which states that ICF coverage is for persons "who, in the absence of intermediate care would require placement in a skilled nursing home or mental hospital." CT Reply Br., p. 19, citing 117 Cong. Rec. 44721 (1971).⁹ This shows, the States argue, that Congress intended Medicaid to cover those individuals in ICFs who otherwise would have been in a mental hospital.

⁹ The legislative history refers to intermediate care as "for persons with health-related conditions who require care beyond residential care or boarding home care, and who, in the absence of intermediate care would require placement in a skilled nursing home or mental hospital." Statement of Senator Bellmon, 117 Cong. Rec. 44720 (1971).

The States argue, in addition, that applying the IMD exclusion to SNFs and ICFs contravenes Congress' intent in other respects. The States point out that the Agency approach can result in denial of Medicaid coverage to all individuals under 65 in an IMD, regardless of diagnosis. Such denial, the States contend, "seems consistent with congressional intent only where mental hospitals are involved, since all residents of such hospitals presumably are mentally ill." CT Br., p. 21.

The States also find the Agency interpretation to be inconsistent with statutory and regulatory prohibitions against discrimination on the basis of diagnosis. We discuss this question below in connection with the Agency's counting of patients with diagnoses of mental disorders in the facilities.

C. Discussion of the Legislative Issues

Both parties have recognized here that not all of the provisions of the statute or the legislative history can be reconciled with either party's position. As the States point out, "The statute is not easy to parse," Tr., p. 29, and, as the Agency acknowledges, "With regard to the legislative history of the terms 'IMD' and 'institutions,' no clear definitions are evident" Cons. Br., p. 37. We conclude below however, that the Agency interpretation is supported by the language of the statute itself and consistent with the legislative history.

The States acknowledge that a private mental hospital, if traditionally used by a State for care of its mentally ill, could be an IMD and could be providing SNF or ICF services. See, e.g., Tr., pp. 115 and 118. This result is compelled by the statutory language, especially viewed in light of its history and context. Although used elsewhere in the statute, the modifier "public" is notably absent from the term "institution for mental diseases."¹⁰

The statute is less clear on the issue of whether the IMD exclusion encompasses private SNFs and ICFs of the type

¹⁰ In Section 1905(a), following paragraph (17), the exclusion for a patient in an IMD appears after a general exclusion for "an inmate of a public institution (except as a patient in a medical institution)." Also, in establishing conditions for States wishing to include coverage of patients 65 or over in IMDs, the statute requires different State plan provisions for such assistance "in institutions for mental diseases," Section 1903(a)(20), and for such assistance "in public institutions for mental diseases," Section 1902(a) (21). See also, the legislative history cited in footnote 1 above.

under consideration here. In using the term "institution for mental diseases" without definition, however, Congress can reasonably be assumed to have given the Agency leeway in determining what institutions would be excluded. Certainly, the term is not specifically limited to "traditional facilities" or to "large, warehouselike facilities" or to accredited psychiatric hospitals.

Further, the structure of Section 1905(a) supports the Agency position. The exclusion appears in reference to each specific level of care: hospital, SNF, and ICF. Although the States' explanation of this is not as "totally illogical" as the Agency says it is, the Agency interpretation that Congress meant to exclude each level of care, regardless of whether a facility encompasses only one or all three levels, makes more sense.

Moreover, we do not agree with the States that the legislative history compels the conclusion that Congress intended that the exclusion never apply to a private, free-standing SNF or ICF. The question simply is not addressed.

Although the legislative history is replete with references to "mental hospitals," there are several factors which make these references less meaningful in resolving the issue with which we are confronted.

As the States themselves point out, the term "hospital" is used differently in the legislative history than in the statute. The record indicates that, at the time the exclusion was originally enacted, a so-called mental hospital was most likely providing only custodial care and would not have qualified as an acute care hospital for Medicaid purposes. Therefore, we do not think that reference to mental hospitals as IMDs in the legislative history precludes a broader interpretation of the statutory term IMD.¹¹ This is particularly true in light of the change in circumstances from the time when the exclusion was

¹¹ Also, the use of the phrase "*in an institution for mental disease*" with respect to the various levels of services in Section 1905(a) does not necessarily imply that the services are provided by a facility that is part of a larger institution. SNF services, for example, are provided *in an SNF* and therefore would be *in an institution* whether the SNF is an institution itself or a distinct part of a larger institution.

enacted to the present. Congress may not have contemplated that the States would use private SNFs or ICFs to fulfill the role that State mental hospitals had traditionally fulfilled, but neither did it state that this could not be so.

Moreover, given that the term "mental hospital" in the legislative history is not defined, and means something different than an institution meeting Medicaid hospital standards, even if we were to substitute this term for the statutory one of "institution for mental diseases" we would be left with an amorphous concept. The States have not clearly delineated a difference between the "traditional mental hospital," providing primarily custodial care, and these facilities here.

The statutory language and legislative history on which the States rely most heavily is related to the 1965 provisions permitting State plans to cover IMD services for the aged. Considered in context, however, the statements are not inconsistent with the Agency position. Section 1902(a)(21) of the Act does refer to nursing homes as an alternative form of care. This section deals, however, solely with *public* IMDs and nursing homes as an alternative to care in public IMDs.

In Section 1902(a)(20), which is not limited to public IMDs, nursing homes are not specifically mentioned as an alternative.¹² The States' reliance on the phrase "readmittance to institutions where needed under alternate plans of care" in this section is also misplaced. As shown by the legislative history, alternate plans can include care in community mental health centers or the patients' own homes. From these alternate plans, readmittance conceivably could include readmittance to an institution which was a nursing home.

Further, the term "institution for mental diseases" for purposes of coverage for the aged is narrower in scope than the definition related to the general exclusion. Under implementing regulations now at 42 CFR § 440.140, to be qualified

¹² To a certain extent, the States' arguments based on these provisions have the same flaw which the States identify with respect to some Agency arguments on the sections. See, CT Reply Br., p. 3, n. 1. Both parties refer to the conditions for coverage as though those conditions determined the scope of the exclusion.

to carry out the provisions of the Act with respect to services to aged recipients, an "institution for mental diseases" must meet general requirements for a psychiatric hospital under Section 1861(f) of the Act.¹³ Given this interpretation, references to mental hospitals as IMDs are less meaningful in the context of services to the aged than if the references had been associated with the general exclusion.

We also conclude that the Agency interpretation does not conflict with the statutory provisions and legislative history related solely to ICFs and relied upon by the States. That Medicaid covers some persons placed in an ICF due to mental condition, where those persons might otherwise have been placed in a mental hospital, does not necessarily mean that it covers all such persons. Under the Agency interpretation, a person with a mental condition is covered in an ICF so long as the ICF is not an IMD and, even if the ICF is an IMD, the person may be covered if over age 65.¹⁴

Moreover, we are not persuaded that the Agency must adopt the description of the exclusion set forth in the court cases cited by the States. Those cases did not directly involve the issue presented here. *Schweiker*, in particular, involved an issue of payment of Supplemental Security Income benefits to inmates of *public* institutions who were not receiving Medicaid benefits. Thus, the Court was only concerned with the exclusion of patients in public IMDs and statements in the opinion must be taken in that context.¹⁵

¹³ The States were given a limited time period in which to bring their institutions up to these standards, but in the meanwhile had to meet other standards, including standards related to safety, to staffing requirements, and to an active program of treatment. See, Handbook of Public Assistance Administration (HPA), Supplement D, Medical Assistance Programs, Section D-5141.14.d.(2) (1966); 34 Fed. Reg. 9784, June 24, 1969 (extending deadline for compliance to July 1, 1970).

¹⁴ We also do not place any significance on the use of the term "public institution for mental diseases or defects" in Section 1905(c) of the Act with reference to ICFs. See footnote 4 above. That provision must be read in light of the exception for ICF services in public institutions for the mentally retarded in Section 1905(d), immediately following this language.

¹⁵ We also note that the statement which provides the strongest support for the States' position is quoted from the dissent rather than the majority opinion in *Schweiker*.

As a matter of policy, the States present an appealing argument that classifying private SNFs and ICFs as IMDs may counteract Congressional incentives to move patients out of the large State mental institutions. The Agency has, however, based its interpretation on the policy judgment that if private, free-standing SNFs or ICFs could never be IMDs, the States might use these facilities as inappropriate substitutes for State institutions rather than as appropriate alternatives.

The Agency interpretation, while not the only possible one, is reasonable and is supported by the statute. Moreover, as we discuss in the following section of our decision, the Agency interpretation that SNFs and ICFs such as those involved here can be IMDs is embodied in duly promulgated regulations.¹⁶

III. The Regulations

The major issue concerning the Agency regulations is whether they were sufficient to give the States notice that the facilities involved should be classified as IMDs. The States contend that the regulations should be read in light of the legislative history of the exclusion to apply only to mental hospitals and are too vague as applied to the SNFs and ICFs here. As discussed below, we conclude that the regulations were clear enough to give the States notice that an SNF or ICF could be an IMD and, in the context of the specific facts here, the regulations were properly applied.

Our discussion of the regulations is divided into three parts: the history and wording of relevant provisions; a statement of the parties' arguments related to the regulations; and our analysis of the issues.

¹⁶ We do not here adopt the Agency's unqualified statement, expressed at the hearing, that the exclusion is meant to continue the States' "traditional financial responsibility for the mentally ill." Tr., p. 21. The exclusion is directed at the States' responsibility for individuals in a certain type of institution. The regulations, in using the term "overall character," reflect this emphasis. The Agency does not deny that Medicaid funding is available for patients with mental diseases placed in a "general" SNF or ICF. Moreover, prohibitions on assistance to individuals with a diagnosis of psychosis who were in general medical institutions were deleted in 1965.

A. Relevant Regulatory Provisions

The Handbook of Public Assistance Administration, Supplement D, Medical Assistance Programs (HPA), published in 1966, restated the statutory provisions concerning IMDs and provided that FFP could not be claimed in medical assistance for—

Any individual who has not attained 65 years of age and is a patient in an institution for . . . mental diseases; i.e., an institution whose overall character is that of a facility established and maintained primarily for the care and treatment of individuals with . . . mental diseases (whether or not it is licensed). HPA, D-4620.2.

HPA provisions were later incorporated into codified regulations. Regulatory provisions at 45 CFR § 249.10, added June 24, 1969, 34 Fed. Reg. 9784, dealt with the amount, duration, and scope of medical assistance. They contained a general limitation on FFP "with respect to . . . any individual who has not attained 65 years of age and who is a patient in an institution for . . . mental diseases." § 249.10(c). "Inpatient hospital services" in which FFP was available were defined, in part, as "for the care and treatment of inpatients . . . in an institution maintained primarily for treatment and care of patients with disorders other than . . . mental diseases . . ." § 249.10(b)(1). Skilled nursing home services were defined, in part, as "furnished by a skilled nursing home maintained primarily for the care and treatment of inpatients with disorders other than . . . mental diseases . . ." § 249.10(b)(4)(i).

Section 248.60, added to 45 CFR at 36 Fed. Reg. 3872, February 27, 1971, contained the provisions with respect to "institutional status" and its effect on availability of FFP under Medicaid. The section basically paralleled HPA § D-4620.2 language on "overall character" of an IMD. 45 CFR § 248.60(a)(3)(ii). It also contained the following definitions:

- (1) "Institution" means an establishment which furnishes (in single or multiple facilities) food and shelter to four or more persons unrelated to the proprietor, and

in addition, provides some treatment or services which meet some need beyond the basic provision of food and shelter.

* * *

- (7) "Institution for mental diseases" means an institution which is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care, and related services. 45 CFR § 248.60(b).¹⁷

Current provisions are similar but reflect the addition of ICF services and of inpatient psychiatric facility services for individuals under age 21 and, also, the change to use of Medicare standards for skilled nursing services. The key definition of an IMD, at 42 CFR § 435.1009, incorporates several earlier provisions as follows:

"Institution for mental diseases" means an institution that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for the mentally retarded is not an institution for mental diseases.

B. The Parties' Arguments on the Regulations

Basically, the States' position is that they had a reasonable expectation of funding for these SNFs and ICFs here because they relied on the legislative history of the exclusion and past practice of the Agency in applying the regulation only to "mental hospitals." The States further argue that, even if the

¹⁷ Sections 249.10 and 248.60 were redesignated, 42 Fed. Reg. 52827, September 30, 1977, and then recodified, 43 Fed. Reg. 45176, September 28, 1978.

regulations could apply to private, free-standing SNFs or ICFs under some circumstances, the regulations were improperly applied here. On the latter point, the States focus on key words in the regulation, arguing either that the terms are too vague or that they should be interpreted a particular way.

For their view that the regulations should be interpreted to refer only to institutions with an "overall character" like a traditional mental hospital, the States rely in part on the legislative history of the exclusion.

They point out that the references to IMDs as mental hospitals in relation to the 1965 Amendments were made only a year before the medical assistance provisions of the HPA were issued. CT Br., p. 5, n. 2. Further, the States argue, the use of the term "overall character" in the regulations is an indication that the emphasis would be on the nature and type of institution rather than on the patients. The States point to those institutions which the States recognize as IMDs, the character of which is "unambiguous and a matter of public knowledge." CA Reply Br., p. 5. Focusing on the nature and purpose of the facilities, the States argue, allows for accepting the published regulations as valid since "[o]nly traditional state mental hospitals or their functional equivalents are truly institutions established and maintained for the purpose of diagnosis, treatment and care of persons with mental diseases." CA Reply Br., p. 5.

The States argue that their interpretation of the exclusion was a long-standing one, and that they acted on the basis of this understanding without attempting in any way to disguise their programs. CA Reply Br., p. 16. On the other hand, they argue, the Agency interpretation is a new one. According to the States, there had been no effort by the Agency to apply the regulatory definition of an IMD to nursing homes until the issuance of a General Accounting Office report, followed by field staff instructions in 1975. IL Reply Br., p. 2. Thus, the States argue, applying the definition to the facilities here amounts to a retroactive interpretation of the regulations.

This "retroactive" interpretation should be disfavored, the States argue, because it leads to "a proposed wholesale recoupment of federal funds," devastating to the States' budgets. CA Reply Br., p. 17. Given this effect, the States contend, the

Board should apply the rationale set forth in the recent Supreme Court case of *Pennhurst State School and Hospital v. Halderman*, 101 S. Ct. 1531 (1980). That decision is relevant, the States argue, because it points up the need to consider the legitimate expectations of the States in grant programs. CA Reply Br., p. 16; CT Reply Br., p. 15.

The Agency does not allege that the regulatory definition had been applied to private, free-standing SNFs and ICFs prior to these disallowances, but argues, "The States' contention that HCFA has in some way changed its policy with regard to the definition of IMD is completely unfounded." Cons. Br., p. 38. In support of this, the Agency points to the HPA, which, it states, "makes clear that hospital, SNF, and ICF services are all defined as services provided in those institutions." Cons. Br., p. 38. In particular, the Agency cites to the definition of a skilled nursing home for Medicaid purposes as one maintained primarily for patients without mental disorders. Cons. Br., p. 38, citing HPA D-5141.14.b. From this, the Agency concludes that the States have clearly known since 1966 that the Agency interpreted IMDs to include nursing homes.

The Agency states that, under the regulatory definition of an institution, hospitals, SNFs, and ICFs can all be institutions. Since the regulation sets no categories of institutions but looks to "overall character," the Agency argues, the regulation "requires an individual institution-by-institution determination, not a blanket prohibition as the states propose." Cons. Br., p. 37.

The States further argue, however, that the terms "diagnosis" and "treatment" in the regulatory definition provide a basis for distinguishing the SNFs and ICFs here from recognized IMDs covered by the definition. According to the States, an IMD performs a diagnostic service "to determine if a person is mentally ill through competent medically accepted, psychiatric techniques of diagnosis," and this is distinguishable from what SNFs and ICFs do, which is "relying upon historical diagnoses or diagnoses from some other institutional setting." Tr., p. 86.

The States also argue that the term "treatment" in the regulation must mean more than the mere "services" which are

provided to anyone in an SNF or ICF. In the States' view, "treatment" as contemplated by the regulation means an attempt to cure, which "involves very active efforts in treating the underlying pathology." Tr., p. 87.¹⁸

The States recognize that SNFs and ICFs provide some services provided by mental hospitals, such as food, shelter, and management of daily problems. Yet, the States assert that this is not sufficient to characterize these facilities as IMDs because "there is no psychiatric component to any of those treatment modalities." Tr. p. 88.

The States challenge the Agency interpretation as so overbroad that under it any institution that provided some treatment or services to a person who is mentally ill would become an IMD. This is inconsistent, the States contend, with the Agency's own regulations which define "institution" broadly, but use IMD as a clearly limited subset of institutions. Tr., p. 85. See also, CA Reply Br., p. 6.

The Agency counters that an institution may be an IMD if engaged in providing diagnosis, treatment, or care, and therefore need not be performing diagnosis. In response to the States' interpretation of the term "treatment," the Agency points out that regulations at 42 CFR § 456.380 require that ICFs provide a plan of treatment. According to the Agency, the regulatory definition of an IMD "mandates that facilities be classified according to the overall character of the patient population, not according to the services provided." Agency response to appeal, Docket Nos. 79-52-MN-HC and 79-89-MN-HC.

Finally, the States point out that the term "mental diseases," not defined in the regulation, is vague. In applying the regulation, the Agency referred to a disease classification

¹⁸ California distinguishes nursing home services from "clinical treatment" performed by recognized IMDs, associating the term "clinical" with treatment provided by psychiatrists and clinical psychologists. CA Reply Br., p. 3, n. 2. The Director of the Illinois Department of Mental Health referred to the distinguishing factor as "psychiatric intervention." Tr., pp. 287, 299.

system known as the ICDA.¹⁹ The States contend that the Agency definition, using mental disorders under the ICDA, was overbroad since it included mental states resulting from an underlying physical disease. CA Supplemental Statement in Support of Application of Review (CA Supp. App.), pp. 44-45, see also, CT. Br., pp. 44-45. The States also allege that the Agency confused use of the terms "mental impairment," "mental disability," and "mental disease" and this led to inconsistent application of definitions.

The Agency responds that—

Congress used the term "mental disease" in 1965 . . . to mean what were commonly known as mental disorders at that time. The [ICDA] is a reasonable guide to the universe of "mental diseases." Establishing a physical cause for "psychiatric symptoms" does not change the fact that "psychiatric symptoms" are what Congress meant when it said "mental diseases." Agency response to appeal, Docket No. 80-184-CA-HC, p. 26.

C. Discussion of the Regulatory Issues

Although there is some basis for distinguishing the issue in the *Pennhurst* case from the issue presented here,²⁰ we agree with the States that the *Pennhurst* rationale is relevant. If the States are to plan their Medicaid programs, they must know on what basis a facility will be classified as an IMD, particularly if that classification can be avoided by choices on patient placement. In examining whether the regulations in question were sufficient to inform the States that they could not expect funding for services in these particular facilities, however, the issue of clarity must be examined in light of the specific facts presented here.

¹⁹ "International Classification of Diseases, Adapted for Use in the United States," Eighth Revision, Public Health Services Publication Number 1693.

²⁰ In *Pennhurst*, the issue was whether a statutory statement of patients' rights imposed an affirmative duty on States to expend their own funds as a condition for receiving Federal funding. Here, we are dealing with the scope of an exclusion of funding, where the States' interest in clear notice must be weighed against the Federal government's interest in not funding services Congress has refused to cover.

The evidence discussed in section V below establishes that very high percentages of patients in these institutions had disorders which were identified as mental disorders under a generally accepted classification system, that the facilities in most instances held themselves out as caring for the mentally ill, that some of the services provided to the patients could reasonably be considered "treatment," and that the facilities had other characteristics supporting the conclusion that the regulations apply. Thus, we are not dealing here with close calls concerning the Agency's application of a questionable criterion; in virtually all cases, the facilities involved had attributes which placed them securely within any reasonable reading of the Agency's regulation.

The States' major argument is that the regulations must be viewed in light of the legislative history of the exclusion and the States' understanding of the exclusion. Since the States viewed the regulations this way, the States claim, they had an expectation of funding for these facilities and the disallowances result from an unfair retroactive interpretation of the regulation. Even if we were to concede that the States interpreted the regulations in light of a certain understanding of the exclusion, we would not necessarily be led to the conclusion that the States' interpretation was reasonable, given the plain language of the regulations.

The regulations state that an IMD is, first of all, an institution. The term "institution" is defined for these purposes as "an establishment that furnishes . . . some treatment or services to four or more persons" This is a longstanding interpretation which is inconsistent with the view that the exclusion applies only to large warehouselike facilities. We are not persuaded that this definition is not significant merely because IMDs are a specific subset of all institutions. There is nothing in the regulations to indicate that the scope of the IMD "subset" is related to institutional size.

Moreover, an institution may encompass a single facility or multiple facilities, and may be public or private. While the regulations do not specifically state that a single, private facility

is an IMD if otherwise meeting the definition, it is a logical implication from the definition taken in context.²¹

The States also argue that the regulations should be interpreted in light of the statement in *Schweiker* that mental hospitals were treating only the mentally ill. This view does not comport with the use of the term "primarily" in the regulations. It is a clear implication from the use of that term that an IMD may also be providing care and treatment to persons other than patients with mental diseases. Moreover, the early definition of inpatient hospital services as services in an institution primarily for persons with disorders other than mental diseases (with the parallel definition of skilled nursing services) indicates that the nature of the patient population is pertinent. While we agree with the States that the term "overall character" reinforces a view that the focus of the exclusion is on the nature of the institution itself, we fail to see how one can totally separate the nature of the institution from the patients it serves.

The States' attempt to distinguish the facilities here from recognized IMDs on the basis that these facilities do not perform diagnostic services and do not provide the same degree of treatment also fails in light of the plain language of the regulation. The term "diagnosis" appears before the disjunctive "or." The regulation cannot reasonably be read to infer that only institutions performing diagnosis are IMDs.²²

With respect to the States' interpretation of the meaning of the term "treatment," we agree with the Agency that this interpretation is inconsistent with the States' own position that

²¹ Congress apparently considered ICFs and SNFs to be institutions. The statutory definition of an ICF at Section 1905(c) refers to persons requiring care which could be made available only through "institutional facilities," and to "institutional services" deemed appropriate in certain sanatoriums. An SNF is defined at Section 1861(j) as "an institution (or a distinct part of an institution)"

²² While the States have presented some evidence that SNFs and ICFs do not perform a full range of diagnostic services, the record does not fully support a conclusion that the facilities here did not engage in some diagnostic functions. In fact, a statement by a psychiatrist from the California Department of Mental Health who testified at the hearing was to the effect that he would not expect an *emphasis* on diagnosis in a SNF. Tr., p. 204. This implies that he would expect some diagnosis to occur.

the regulation should be read in light of the legislative history and the circumstances at the time the exclusion was originally enacted. Congress has provided incentives to upgrade the quality of treatment in mental institutions and to ensure "active" psychiatric treatment for individuals for whom Federal funding would be available. See, Sections 1902(a)(20) and 1905(h)(1)(B)(i) of the Act. There is a substantial question, however, whether recognized IMDs were providing this kind of treatment at the time the exclusion was enacted. We also note that the regulation speaks of treatment *of* persons with mental diseases, not treatment *for* mental diseases.

Contrary to other statutory and regulatory provisions which specify a certain type of treatment, the regulatory definition of IMDs merely says "treatment." The States have pointed to nothing that supports a conclusion that the SNF and ICF services here did not constitute "treatment" within the meaning of the regulation.²³

The term in the regulation which is most readily subject to various meanings is the term "mental diseases." Here, again, the States' arguments have internal contradictions. While the States accuse the Agency of using an overbroad definition in light of current knowledge of the causes of mental symptoms, the States have not shown that that definition was broader than those categories of persons treated in mental hospitals at the time the exclusion was enacted.

The States would have us overturn the Agency determinations since the Agency included patients with mental disorders where the States say the primary diagnoses were physically-based diseases, and since the Agency included patients whose diseases were probably misdiagnosed. The regulations, however, merely say "persons with mental diseases." Thus, to the extent that the Agency evaluated patients at all on the basis of

²³ The States' position that these nursing homes were providing a level of services which does not constitute treatment of patients also does not comport with numerous statutory and regulatory uses of the terms. For example, Section 1905(c) of the Act describes ICF services as those for persons who do not require the "degree of care and treatment" provided by an SNF. Also, the original definition of skilled nursing home services included reference to homes for "care and treatment" of patients. HPA D-5141.4.

primary rather than secondary diagnosis, this was a narrowing of the regulation from which the States benefited. Moreover, for the most part, even excluding patients with physically-based mental disorders, these facilities were serving primarily persons with mental diseases.

We agree with the States that the Agency sometimes may have confused the use of various terms related to mental status. In clarifying proper usage, however, California's expert states, "Impairment and disability are terms describing the effects of disease on functioning, while disease is a diagnostic concept." CA Supp. to App., Exhibit C, p. 53 (footnote omitted). Since the Agency findings are related to diagnosis, we conclude that Agency misuse of terms, while unfortunate, did not prejudice any State and is consistent with Congress' use of the term "mental diseases."

Moreover, we agree with the Agency that its use of the ICDA was reasonable. The States have not disputed that the ICDA is a generally recognized classification system. While the States' testimony establishes that the ICDA is subject to some difficulties in application, it also establishes that any attempt to classify illness presents such difficulties. To preclude the Agency from adopting any classification system at all would render the exclusion totally unenforceable.

Thus, we conclude that the regulations were sufficiently clear to inform the States that these facilities were IMDs and funding would not be available for services to patients in the facilities. Given that the regulations are sufficiently clear to apply to these facilities, to the extent that the States relied on the fact that the exclusion had not been applied to this type of facility before, that reliance is unreasonable. Moreover, the Agency should not be precluded from fully enforcing a regulation merely because it has never been applied a particular way in the past. The Agency must be able to respond to changing circumstances, by enforcing an existing regulation.

IV. The Criteria

Thus far, we have considered the States' arguments related to Congressional intent and to the regulations themselves. In

this section, we consider the States' arguments concerning the Agency criteria for applying the regulations, set out in instructions to field staff. We conclude that these arguments also do not provide a basis for overturning these disallowances.

Our discussion of the issues related to the criteria is divided into five parts: the history of development of the criteria; the parties' arguments on procedural issues related to the criteria; our analysis of the procedural issues; the parties' arguments on substantive issues related to the criteria; and our analysis of the substantive issues.

A. History and Statement of the Criteria

The Agency "criteria" for determining IMD status were set forth in a series of documents which were part of an Agency transmittal system called the Field Staff Information and Instruction Series (FSIIS). FSIIS FY-76-44, dated November 7, 1975, was addressed to the Regional Commissioners of the Social and Rehabilitation Service (SRS), then responsible for administering the Medicaid program, and informed them that regional office findings and a General Accounting Office study had indicated that FFP was being improperly claimed for Medicaid for individuals between 21 and 65 in IMDs. This document cites the regulatory definition of IMDs and states:

The character rather than the licensure status of the institution is of paramount importance An institution is characterized as "primarily" one for mental diseases if it is licensed as such, if it advertises as such or if more than 50 percent of the patients are in fact patients with mental disease. In some instances a facility may be "primarily" concerned with such individuals because they concentrate on managing patients with behavior or functional disorders and are used largely as an alternative care facility for mental hospitals, even if less than 50 percent of the patients have actually been diagnosed as having a mental disease. Mental diseases are those listed under the heading of mental disorders in the [ICDA], except that mental retardation is not included for this purpose.

The document requested information from the regions on the problem of improper claiming for services in IMDs, stating

that the focus should be on SNFs and ICFs since "we assume, absent evidence to the contrary that improper claims related to age are not a problem for care in psychiatric hospitals."

FSIIS FY 76-97, issued May 3, 1976, stated that responses to the earlier instruction "have heightened our awareness of great discrepancy in the understanding, interpretation, and implementation of policy" with respect to IMDs. The document points to the regulations as a basis for the conclusion that free-standing SNFs and ICFs may of themselves be IMDs, expresses concern with improper claiming, and advises regions to "assess or continue to assess the situation as it now exists in order to assist the States where necessary in complying with applicable Federal Regulations."

A third document, FSIIS FY-76-156, dated September 14, 1976, addressed mental health under Title XIX in general and noted progress in the efforts to assure observation of the prohibition on funding in IMDs. This document referenced the earlier transmittals and stated:

Various methods in addition to those discussed in earlier issuances have been suggested to help States identify suspect facilities, including proximity to State institutions (for example, within a 25-mile radius) and age distribution uncharacteristic of nursing home patients (i.e. a preponderance of individuals under age 65). Also, included in these methods would be a determination as to whether the basis of Medicaid eligibility of patients under 65 in suspect facilities was due to mental disability.

FSIIS FY-76-156 recommended use of review teams "to review patients in those facilities where the determination [of IMD status] cannot be made without applying the 50% criterion." It also set out a system for classifying patients, according to physical problems and mental disability, to determine whether the person's need for skilled nursing or intermediate care resulted from a mental disability.

In a memorandum to the Regional Attorney, Region IX, HEW, dated September 16, 1977, the regional office requested

a legal opinion on the criteria set out in the FSIS series, summarizing the criteria as follows:

1. Licensed as mental institutions.
2. Advertises as mental institutions.
3. More than 50 percent of the patients have a disability in mental functioning.
4. Used by mental hospitals for alternative care.
5. Patients who may have entered mental hospital accepted direct from community.
6. Proximity to State mental institutions (a 25 mile radius).
7. Age distribution uncharacteristic of nursing home patients.
8. Basis of Medicaid eligibility for patients under 65 due to mental disability.

Attachment IV to Appendix D to CA Audit Report.

The October 28, 1977 response, prepared by an Assistant Regional Attorney, expressed the opinion that the criteria were interpretative rules which "constitute both clarification and more specific explanation of existing law and regulations." Appendix E to CA Audit Report. The Assistant Regional Attorney's memorandum, included with all but one of the Agency audit or review reports used here, further states:

Obviously some of the above listed criteria are more probative as to whether a facility, given its "overall character", is "primarily" engaged in IMD type activity, e.g. the fact that a facility is used by mental hospitals for alternative care (#4) is more probative than the fact that a facility happens to be located within a 25 mile radius of a state mental institution p. 8.

The memorandum warns that "every indication of any significance that a given facility is primarily engaged in IMD activity should be marshalled to fulfill the regulatory mandate

that the determination be on the basis of the facility's 'overall character'" pp. 8-9.

The auditors and reviewers making the determinations disputed here all used four or more of the criteria. Two additional factors, considered by the reviewers in Connecticut were—

9. Hires staff specialized in the care of the mentally ill.
10. Independent professional reviews conducted by state teams report a preponderance of mental illness in patients in facility. CT Review Report.

With respect to the criteria, the States raise a number of procedural arguments. They also attack the criteria substantively, particularly challenging the so-called "51% rule" (Criterion #3) as inconsistent with the statute and regulations and with prohibitions on discrimination on the basis of diagnosis. The States allege that the criteria were inconsistently applied by the Agency and present serious administrative difficulties.

B. The Parties' Arguments on Procedural Issues

The States first argue that they did not have timely notice of the criteria and therefore cannot be adversely affected by the criteria since the criteria were not published in the Federal Register. In support, the States cite 3 U.S.C. § 552(a)(1).

Whether the criteria are substantive rules or interpretative rules, the States contend, they should have been published because they have "general applicability." This "general applicability" is shown, in the States' view, by the "fact that HCFA issued the criteria to all SRS regional commissioners and has used them as a basis for disallowances against four states" CT Br., p. 33. The States cite the case of *Appalachian Power Co. v. Train*, 566 F.2d 451, 455 (4th Cir. 1977), for the proposition that information is required to be published under § 552(a)(1) if it is "of such a nature that knowledge of it is needed to keep outside interests informed of the agency's requirements in respect to any subject within its competence."

The States also argue that, under the Department's own regulations,²⁴ the criteria should have been published in accordance with the notice and comment rulemaking procedures of Section 4 of the Administrative Procedure Act (APA), 5 U.S.C. § 553. Since this section applies only to substantive rules, the States allege that the criteria were more than an interpretation clarifying or explaining existing law, and, in this connection, point out that the label assigned to a rule by an administrative agency is not determinative. CT Br., p. 35, citing *Anderson v. Butz*, 550 F. 2d 459, 463 (9th Cir. 1977); *Continental Oil Co. v. Burns*, 317 F. Supp. 194, 197 (D. Del. 1970).

Further reason why the criteria should have been published, the States argue, is that the criteria had a "substantial impact" on the States. Using the test for "substantial impact" set forth in *Continental Oil Co.*, *supra*, 317 F. Supp. at 197, the States present an analysis to show that the criteria are complex and pervasive; represent significant changes from existing law; have retroactive effect; and have engendered confusion and controversy. CT Br., pp. 36-37; see also, IL Application for Review, pp. 10-11; Tr., pp. 74-76. Based on this analysis, the States conclude that the Agency's failure to use notice and comment rulemaking to promulgate the criteria renders them invalid.

Finally, the States attack the criteria as procedurally defective on the grounds that use of the criteria without giving notice to the States of the criteria themselves, of the Agency's intent to use them as an enforcement tool, and of the meaning of the criteria violates principles of due process and fundamental fairness.

The Agency does not dispute that the States may not have had notice of all the criteria, Tr., pp. 18-19, but explains its position as follows:

The criteria . . . discussed in the FSIIS's were never intended to be criteria as such. They were merely

²⁴ On February 5, 1971, the Department of Health Education, and Welfare (HEW, now HHS) adopted notice and comment rulemaking for matters relating to "public property, loans, grants, benefits or contracts," otherwise exempted under the APA. 36 Fed. Reg. 2536.

guidelines. . . . they merely discuss the central office's view of what factors might be helpful in locating, identifying, possible IMD's and evaluating possible IMD's. They were never intended to be the kind of criteria that you would assign a numerical score to, and none of the criteria was ever considered determinative with respect to the nature of the facility. Tr., pp. 15-16.

In support of this, the Agency points to inclusion, with the reports, of the Regional Attorney's legal opinion on applying the criteria in relationship to the regulation. Tr., p. 16.

According to the Agency, the criteria are interpretative rules, constituting clarification of existing policy embodied in the duly promulgated regulations; they were not required to be published because they were not "for the guidance of the public."²⁵

The Agency further argues that the FSIIS "include obvious factors for determining which institutions might be primarily engaged in the treatment of persons with mental diseases. Cons. Br., p. 44. There is nothing confusing, drastic, or retroactive about the criteria, the Agency states, since they merely aid in the implementation of HCFA policy that has been clear and consistent since 1966." Cons. Br., p. 44. See also, Tr. p. 16.

C. Discussion of Procedural Issues

In view of our conclusion above that the regulation itself was sufficiently clear to give the States notice that these

²⁵ In support of this, the Agency cites the *Attorney General's Manual on the Administrative Procedure Act* (1947) at 22 for the statement that "interpretations need be published only if they are formulated and adopted by the agency for the guidance of the public. The Act leaves each agency free to determine for itself the desirability of formulating policy statements for the guidance of the public." Cons. Br., p. 42; see also, Tr., p. 18. We note that the version of 5 U.S.C. § 552(a)(1) quoted by the Agency appears to be an earlier version, prior to the 1967 amendments, Pub. L. 90-23. The Agency version contains the phrase "for the guidance of the public" as a description of covered interpretations, whereas the current version places the phrase in the introductory language, requiring publication "for the guidance of the public." In view of our conclusion below, we do not address the significance of this difference.

particular facilities were IMDs, we conclude that the Agency's failure to publish or otherwise give the States notice of the criteria would not provide a basis for overturning these disallowances. The adverse effect, and financial impact, of these disallowances is a result of the regulations rather than the criteria since these facilities had the requisite "overall character" under any reasonable reading of the regulation. Thus, we cannot say that the Agency's actions prejudiced the States, given the circumstances presented here.

The FSIIS series documents show that the Agency viewed the criteria as indicators of whether a facility was an IMD under the applicable regulations. The Agency used some or all of the criteria in making each of the disallowance determinations here, but none of the criteria was considered determinative. The cumulative evidence is that the facilities met the regulatory definition.

We also note that many of the States' arguments with respect to the need for notice or publication are premised on the view that the criteria amounted to a change in existing law, since their understanding was that only mental hospitals were IMDs. As stated above, the regulations in context clearly imply that private, free-standing SNFs and ICFs can be IMDs. Moreover, while it is unclear from the record at what point the States had actual notice of the criteria themselves, it appears likely from the record that the States were aware prior to the periods of disallowance that the Agency interpreted the regulation as applying to such SNFs and ICFs.²⁶

²⁶ The FSIIS series documents indicate that the regional offices were to involve the States in addressing the problem of whether SNFs and ICFs were IMDs. There is also other evidence that some of the States knew of this application of the regulation. See, e.g., Letter of October 4, 1971 from Associate Regional Commissioner, SRS, to Director CA Department of Health Care Services (relating the IMD exclusion to services provided "by nursing homes or in hospitals"), Agency Admin. Record, Tab 1; Tr., p. 129 (Testimony of Connecticut Public Assistance Consultant that "around 1976" her Department was aware of the position that ICFs and SNFs could be IMDs); Letter of December 29, 1977, from Assistant Commissioner, Minnesota Department of Public Welfare, Attachment 6 to MN Audit Report.

D. Substantive Issues Related to the Criteria

The States also attack the criteria substantively, focusing primarily on the Agency's counting of patients with mental disorders (Criterion #3), but also making some general arguments. The parties' substantive arguments are summarized below, followed by our analysis.

1. Substantive Arguments Related to the Counting of Patients

The States direct their substantive attack on the criteria mainly against Criterion #3, referred to as the "51% Rule," arguing that it is arbitrary, invidious, and contrary to prohibitions against discrimination on the basis of diagnosis. For support of their proposition that the counting of patients is discriminatory, the States cite Social Security Act provisions which forbid a State from discriminating against any eligible individual with respect to the amount, duration, and scope of medical assistance, Section 1903(a)(10), and regulations which prohibit a State from denying a required service to an otherwise eligible individual solely because of diagnosis, type of illness, or condition. 42 CFR § 440.230. The States also cite a policy guide and other Department issuances which reflect a policy of nondiscrimination on the basis of diagnosis. CT Br., pp. 25-26. Moreover, the States argue, the Agency approach "encourages segregation of individuals with mental diagnosis in certain facilities on the basis of considerations other than their individual needs," and thus violates Section 504 of the Rehabilitation Act of 1973, as amended. CT. Br., p. 28.

In response, the Agency asserts,

The statute provides, quite simply, that no FFP is available for services provided in an institution for mental diseases. . . . once a facility is determined to be an IMD, no federal financial participation is available for services to any resident of the facility, whether or not a resident is mentally ill. . . . To paraphrase the Supreme Court's holding in *Schwicker v. Wilson*, . . . the distinction is not between the mentally ill and a group composed of the nonmentally ill, but rather between residents of IMDs and

residents of other long-term care facilities. Cons. Br., p. 53.

Other problems which the States raise with respect to Criterion #3 include the arbitrariness of diagnostic labeling of patients, the difficulties of categorizing patients with multiple disorders, the problems inherent in using the ICDA, the unreliability of medical records, and the administrative headaches potentially caused by changes in patient population. The States presented testimony that the fact that a patient once carried a label of being mentally ill had nothing to do with the current status of the patient, and, since the auditors did not engage in a procedure to determine whether a patient still had an acute, active illness, use of a previously-given diagnosis amounted to "gross prejudice." Tr., p.279; see also, Tr., p.298. According to the States, diagnosis is a judgmental process, which may depend in part on the particular specialty of the doctor engaged in the process. Determining reasons for placement in a particular facility is particularly complex with respect to patients with multiple diagnoses, the States point out, with supporting testimony. Tr., pp. 187-188.

The States attack the use of the ICDA as a basis for categorizing patients by presenting testimony that SNFs and ICFs have no legal restrictions in terms of using the ICDA and concluding from this that an Agency reviewer might be confronted with diagnoses which do not fit the ICDA categories. Tr. pp. 182-183. The States also argue that a "51% Rule" is completely unworkable because patient population can shift and, under the rule, admission of one additional patient with a mental disorder could result in loss of Medicaid coverage for all patients in a facility.

The Agency in rebuttal presented testimony by a psychiatrist who was on the review team which examined the Connecticut facility involved here. He stated that he carefully weighed judgment as to why a patient with multiple diagnoses was placed in the Connecticut facility. He further expressed the opinion:

I don't think non-medical or non-nursing auditors would be able to have necessarily the same kind of

credibility that I was able to have concerning the medical records. But if you assume that they are accurate and of reasonable quality, they do give you, I think, an accurate understanding of what is being treated. Tr., p. 331.

The Agency also defends use of the ICDA as a reasonable guide to the universe of "mental diseases," given that "complete agreement cannot be revealed with regard to systems of diagnosis" Cons. Br., p. 46. The Agency points out that trained medical staff conducted or aided in the review of patient records and claim forms here in order to establish diagnosis. The Agency states that its evidence shows that "the review terms were if anything very cautious and conservative in their applications of the categories." Cons. Br., p. 47, citing Tr., pp. 312-407.

In general, the Agency argues:

As stressed in the controlling regulation, it is the overall character of the facility, and not merely the percentage of residents with diagnoses of mental illness, that is determinative. Moreover, the FSIISs specifically recognized the problems inherent in the arbitrary application of a percentage standard, under which a facility's status could change day-to-day. It made clear that the character of the facility would be determined once, and that status would continue until a special request to change it was filed: . . . FSSIIS (sic) FY-76-156 at 3. Thus, the admission of one patient with mental illness would not affect the character of a facility. Cons. Br., p. 52.

2. General Substantive Issues Related to the Criteria

The States attack all the criteria on substantive grounds as impermissibly vague and the Agency's use of the criteria as arbitrary and capricious. In general, the States argue that the criteria "are ill-defined, and they appear to be wholly inadequate indicators of whether an institution meets the 'primarily engaged' or 'overall character' standards of the published regulations." CT Br., p. 42; see also, Tr., pp. 100-101. With respect to specific criteria, the States challenge each of them as

"meaningless," "incomprehensible," "misleading," or otherwise irrelevant to the question of whether a facility is an IMD.²⁷

The States also allege that the criteria were inconsistently applied. The States attribute this, in part, to what they say is a lack of objectivity to the criteria. Applying the criteria presents serious administrative difficulties, the States allege, because this method of identifying IMDs "involves a number of highly judgmental elements (e.g., what is 'mental disease,' how to deal with multiple diagnoses, how to categorize 'senility') which make it impossible for auditors to classify the facility, which make any classification likely to be both subjective and time-consuming, and which will inevitably lead to legitimate heated disagreements with the findings." CA Reply Br., p. 13; see also, CT Reply Br., pp. 8, 16.

In response, the Agency states:

The "criteria", while varying widely in relative importance, are all useful in identifying possible IMBs. As indicated in the review reports that support the disallowances, none of them was ever deemed sufficient in itself to classify an institution. Cons. Br., p. 45-46.

The Agency argues that, in criticizing the Agency criteria but failing to suggest reasonable alternatives, the States appear to be saying that it is impossible to define an IMD and this would render the exclusion unenforceable. Tr., p. 20.

3. Discussion of the Counting of Patients

We agree with the States that there are difficulties with counting patients according to diagnoses based on medical records and with use of the ICDA. We also agree that it is not conclusive that a person is mentally ill merely because at one

²⁷ See, e.g., CA Application for Review, p. 9; CT Br., p. 42; Tr., p. 93 (Criterion #1); CA Application for Review, p. 9; CT Br., p. 43; Tr. p. 94 (Criterion #2); CA Application for Review, p. 10; CT Br., p. 47 (Criterion #4); CA Application for Review, p. 10; CT Br., p. 48 (Criterion #5); CA Application for Review, p. 10; CT Br., p. 49; Tr., p. 98 (Criterion #6); CA Application for Review, p. 10; CT Br., p. 49 (Criterion #7); CA Application for Review, p. 10; CT Br., p. 50 (Criterion #8).

time the person was diagnosed as mentally ill. With a few exceptions discussed in Section V below, however, the States' arguments on these points are generalized and speculative. The States have presented no evidence that, in any of these cases, the determination that the facility was an IMD was based solely on a finding that 51% of the patients had mental diseases.

As stated above, the Agency was reasonable in looking to patient population as a factor in determining "overall character" of a facility. Moreover, given the very difficulties in diagnosis and classification which the States point to, some choice had to be made of how to determine whether a resident was a person with a mental disease. The Agency did include some patients whose psychiatric symptoms might have been physically-based. On the whole, however, the Agency took a conservative approach, employing a current, generally recognized classification system. This approach benefited the States when viewed in light of the common understanding of the term "mental diseases" at the time the exclusion was enacted.

The Agency witness was persuasive on the general reliability of medical records and the ability of auditors to interpret them with relative accuracy. For the Agency to take some risk of misclassification was reasonable, where the patient population was not the sole basis for determining "overall character." While the ideal might be to engage in a lengthy diagnostic analysis to determine reasons for patient placement, it is simply administratively infeasible. We agree with the Agency witness, Tr., p. 331, that the degree of credibility in the medical record needed to understand what is going on is less than what would be demanded if someone were using it as a basis for treatment. Moreover, the States' arguments with respect to unreliability of records and possible misdiagnosis of patients ignore the consideration that, not only the Agency, but the facilities and the States were likely also dependent on historical diagnoses for their decisions on the appropriateness of placement. Even though a diagnosis of mental disease might be wrong, if it was a basis for placement of the patient in a facility, it is an indication of the nature of the facility as one engaged in care and treatment of mental diseases.

As stated above, we also think that the States benefited from the Agency excluding patients who were placed in the facility due to a physical problem even though they may have also been mentally ill. The regulation covers facilities for care and treatment of "persons with mental diseases," and this is not limited to persons with a primary diagnosis of mental disease.

We share the States' concern with administrative difficulties which might be caused by a shift from 49% to 51% population of mentally ill in a facility. This concern is irrelevant here, however, given the high percentages of mentally ill in most of the facilities during the disallowance periods and since other significant factors also evidenced "overall character" of the facilities as IMDs.

We also do not find the counting of patients here to be discriminatory. As the Court in *Schweiker, supra*, found, the exclusion is directed at a type of institution, not at the patients. The resulting disallowances flow from classification of a facility as an IMD, not from the counting of patients per se. This classification may have unfortunate results on placement decisions made by the States, and lead to mentally ill patients being segregated in IMDs or placed in facilities farther from their homes so that the exclusion could be avoided. However, any discrimination in this situation would be a result of the exclusion and the State seeking to maximize funding, and only tangentially the result of the Agency's counting of patients.

We also note that Medicaid provisions forbid denial of "medical assistance" on the basis of diagnosis. The Agency is using diagnosis here as a basis for determining whether services are, indeed, "medical assistance" or are excluded from being "medical assistance" because they are provided in an IMD.

Our holding here does not imply that the Agency could never apply a "51% Rule" arbitrarily. Given the facts of these cases, however, the criterion itself does not provide a basis for reversal of the disallowances.

4. Discussion of General Substantive Issues Related to the Criteria

With respect to the remaining criteria, we also find that they were applied here in a reasonable manner. If the Agency had relied solely on any one of them, we might view the issue differently. The Agency itself recognized, however, that some of the criteria were more probative than others and here used the criteria as a guide for accumulating evidence that the regulatory definition was met.

While all of the criteria might not be as obvious as the Agency alleges, neither are they as obscure as the States allege. In these particular cases, the findings which result from the Agency's use of the criteria do support the general conclusion that the facilities were IMDs, or, at least, do not detract from that conclusion.

There was some inconsistency in application of the criteria to the different States' facilities. For the most part, this merely reflected the differences in the States' programs and did not prejudice any State since the inconsistency in no case led to a legally incorrect application of the regulation. Further, the inconsistency in some instances favored the States since the Agency may have applied the criteria more conservatively than the regulations required.

Thus, given our conclusion that the regulations apply as a basis for the disallowances here, we further conclude that the Agency's failure to promulgate the criteria does not render these disallowances defective, and that, substantively, use of the criteria as tools for the application of the regulations was not arbitrary or discriminatory. We also conclude that while the criteria in some instances may have been inconsistently applied, these instances were not prejudicial and do not invalidate the Agency's findings as a whole. As discussed below, the Agency has presented persuasive evidence that each of these facilities met the regulatory definition of an IMD.

V. Analysis of Factual Issues

In this section, we discuss the facts related to the disallowances for each of the four States involved here, analyzing

the issues each State raised with respect to its particular case. The order of discussion (Connecticut, Illinois, Minnesota, and California) is the order in which the States presented their arguments at the joint hearing. Each subsection is organized differently, depending on the types of issues the particular State raised.

A. Connecticut

Docket No. 80-150-CT-HC involves a disallowance of FFP claimed by the State of Connecticut for services provided by Middletown Haven Rest Home (Middletown Haven), during the period January 1, 1977 through September 30, 1979. The disallowance was based on a report submitted by an Agency regional office review team,²⁸ which found that Middletown Haven was an IMD.

For reasons discussed below, we conclude that Middletown Haven was an IMD and uphold the Agency's disallowance.

1. The Reviewers' Findings in Connecticut

Both the Review Report itself and testimony at the hearing by the psychiatrist member of the review team show that the determination that Connecticut's Middletown Haven ICF met the regulatory definition of an IMD was based on careful consideration of a number of different factors. The reviewers specifically recognized that the criteria were factors to be cumulatively weighed, that they were not intended to be all-inclusive, and that they did not carry equal weight. CT Review Report, pp. 5-6.

The reviewers found that, during the disallowance period, Middletown Haven was certified as an ICF under the Medicaid program, but also had a license from the State with an "authorization to care for persons with certain psychiatric

²⁸ "Review of Costs Claimed by the Connecticut Department of Income Maintenance for Services Provided to Title XIX Recipients Residing at Middletown Haven Rest Home, Middletown, Connecticut, for the period January 1, 1977 through September 30, 1979," FM Control No. 3-8001, May 1980 (CT Review Report), submitted with agency response to the appeal.

conditions" ("psychiatric rider"). CT Review Report, p. 6, and Attachment D. The reviewers reported:

The staff of the facility stated that not only is it identified in the license but that they view the facility as a psychiatric facility. Statements were made with regard to the patient population that it consisted mostly of mentally ill patients, for the most part transferred from . . . a State mental institution. Also, the statement was made that local hospitals have been advised of this specialty and will specifically refer patients with mental impairments Other indications were given during the interview that supported the team's conviction that the facility administration regards its license seriously and viewed itself as a licensed facility for psychiatric conditions. CT Review Report, p. 6.

The other indications the reviewers relied on included that the facility advertised itself to sources of referral as a facility specializing in the care of persons with mental diseases. This finding was based primarily on statements by the facility's administrator, but was partially verified through other means. CT Review Report, p. 7.

The reviewers also found that Middletown Haven hired medical and other staff which specialized in care of the mentally ill. The facility had a contract with three psychiatrists, requiring each of them to be an active staff member, to come in at least weekly for consultation on patients, and to participate in in-service education programs for the staff. CT Review Report, p. 12.

The factor which the reviewers thought indicated most clearly that Middletown Haven was "primarily engaged" in treating the mentally ill was the determination that, of the 469 patients deemed to have been patients in the facility from January 1977 to December 18, 1979, 364 or 77% had a major mental illness which was a substantial part of their need for ongoing ICF care.²⁹ CT Review Report, pp. 7-8 and Attachment F, p. 3.

²⁹ The 77% here included patients with diagnoses of alcoholism or organic brain syndrome where the record indicated that "the psychiatric
(footnote continues)

This determination was based on a very careful review of the available data, under the guidance of the psychiatrist on the team, who performed an in-depth analysis of a test sample and a detailed review of all cases where other team members had a question about how to classify a patient. CT Review Report, p. 8. This psychiatrist testified at length at the hearing on the rationale he applied to patients with multiple diagnoses. See, Tr., pp. 312-328.

Additional review findings included [sic] that a large proportion of Middletown Haven patients came from State mental institutions, that the facility is within three miles of a State mental institution, and that approximately two-thirds of the patients were between the ages of 21 and 65, which is uncharacteristic of nursing home patients in general. CT Review Report, pp. 8-11. The reviewers also cited an Independent Professional Review report, prepared by State teams, which commented on the "high incidence of psychiatric patients" in the facility. CT Review Report, p. 13.

2. Analysis of the Issues in Connecticut

Connecticut does not dispute the correctness of the reviewers' findings with respect to the facility's specialization and staffing, but does question their relevance. Connecticut contends that the specialization at Middletown Haven can be explained because it makes economic sense to have some concentration of individuals with a particular condition, so that some specialized services can be developed. CT Reply Br., p. 23. Given some concentration of patients with mental problems, it was logical, Connecticut argues, for the facility to seek staff with some relevant experience. Indeed, Connecticut

(footnote continued)

causes, complications or sequelae of these disorders were a significant part of the patients' ongoing need for ICF placement." CT Review Report, Attachment F, p. 2. The psychiatrist from the review team stated that the conclusion that a majority of the patients in the facility were mentally ill would still be valid, even excluding these categories. He further explained that the reason for including them was "their appearance as major mental disorders in ICD-8, DSM II, and all major textbooks of psychiatry, and the fact that the State of Connecticut treats this class of mentally ill in its state mental hospitals . . ." Attachment F, p. 2.

asserts, federal regulations require a facility to have a staff that meets the needs of its residents. CT Br., p. 51. Connecticut also points out that the Medical Director of Middletown Haven was a general practitioner, not a psychiatrist, CT Reply Br., p. 20, and that many long-term care facilities have some staff with experience in caring for mentally disturbed residents. CT Br., p. 51.

The evidence shows, however, that the degree of specialization which occurred at Middletown Haven was significant. The staff viewed Middletown Haven as a psychiatric facility, primarily caring for the mentally ill. Whatever the facility's motivation for concentrating on the mentally ill, we find that the resulting situation strongly indicated that the facility had the "overall character" of an IMD. We also do not think, based on the record, that Middletown Haven was a typical general ICF in the services it offered. The Agency presented convincing testimony by the review team psychiatrist that the level of psychiatric treatment offered by Middletown Haven to its residents was greater than one would normally expect in ICFs. Tr., p. 328.

Connecticut did attempt to factually rebut some of the reviewers' other findings, primarily through the testimony of a Public Assistance Consultant for the Connecticut Department of Income Maintenance. This consultant testified that a "psychiatric rider" to a Connecticut nursing home license merely means that the facility cares for at least one mentally ill patient and has one staff person with psychiatric training. The witness further testified as to the differences between Middletown Haven and State mental hospitals, including that a State hospital provides a greater intensity of treatment and cares for patients with "acute mental disorders." Tr., pp. 138-140. Middletown Haven's admission policy did not permit it to care for persons with acute mental disorders. CT Review Report, Attachment E, pp. 1, 3.

The Connecticut witness also discussed the results of a review she had performed, based on reports by Independent Professional Review (IPR) teams in accordance with federal utilization control requirements. The witness testified that she

would not have concluded from her examination of these reports that in December 1979 a majority of Middletown Haven's patient population were persons with mental diseases. Tr., pp. 143-149; see also, Affidavit, Exhibit D to CT Br. She also gave examples of patients, with multiple diagnoses, whom she thought may have been misclassified by the reviewers as mentally diseased.

While we accept Connecticut's evidence as to the meaning of the "psychiatric rider" on Middletown Haven's license, and certainly would not view the presence of such a rider as determinative of the character of a facility, the fact that Middletown Haven had such a rider has some weight when viewed in the context of the other evidence here. We also are persuaded that there were distinctions between Middletown Haven and State mental hospitals during the disallowance period. Given the regulatory definition of an IMD, however, the fact that Middletown Haven was unlike a mental hospital in some respects is irrelevant to the issue of whether it was an IMD.

On the whole, we find the Agency evidence more persuasive with respect to the reasons for patient placement in Middletown Haven. The testimony of Connecticut's witness on possible misclassification was based on speculation from her review of the IPR reports, not on first-hand knowledge of what the reviewers did.

Moreover, we find that, as between the two witnesses, the Agency witness had more credibility. The Agency witness was highly qualified in psychiatry, Tr. pp. 309-310, whereas Connecticut's witness was not, Tr. pp. 144-145. Even if we agreed with Connecticut that some mistakes may have been made with respect to classification of individual patients, however, there would still remain overwhelming evidence that the "overall character" of Middletown Haven was that of a facility established and maintained for the care and treatment of persons with mental diseases.

Accordingly, we uphold the disallowance of \$1,634,655 claimed by the State of Connecticut for payments to Middletown Haven for quarters ending March 31, 1977 through September 30, 1979.

B. Illinois

Docket No. 80-44-IL-HC involves a disallowance of FFP claimed by the State of Illinois for services provided to persons under 65 years of age in nine ICFs and SNFs during quarters ending December 1, 1976 through September 30, 1978. The Agency concluded that the nine facilities were IMDs based on a comprehensive review of eleven Illinois long-term care facilities. The review was conducted by two Medicaid Program Specialists from the Regional Medicaid staff.³⁰

1. The Reviewers' Findings in Illinois

The reviewers examined medical review or independent professional review documents as well as utilization review data prepared by the Illinois Department of Public Aid and Public Health. These documents were prepared by registered nurses employed by the State and contained the diagnoses and treatment for each Medicaid patient, as recorded in the patient's actual medical records. Diagnoses in the ICDA were used to classify persons with mental diseases. The reviewers also examined advertisements, residents' handbooks, newspaper articles and internal State memoranda concerning the facilities.

The number of Medicaid patients with mental diseases in each of the facilities was found to represent at least 60% of the Medicaid population.³¹ In all but two facilities, the number exceeded 85%. Statements in reports prepared by the Illinois Department of Public Health and Public Aid confirmed for six of the facilities that resident population was made up primarily of mental patients or that the type of care was oriented towards mental patients. In the remaining three, the reviewers pointed to statistics concerning the use of each facility as alternative

³⁰ See "Report on Review of Institutions for Mental Diseases under the Medicaid Program," March 5, 1979 (IF Review Report).

³¹ The Illinois, Minnesota, and California reviews examined only records of Medicaid patients, and, therefore, the percentages found were percentages of the total Medicaid population, not the total patient population, for each facility. The States have presented nothing, however, which would lead us to conclude that the Medicaid population was not representative of the total population. The assumption that it was appears to be reasonable.

placement for mental hospitals or the number of former mental hospital patients in the facility. The reviewers noted that in five of the facilities, the average age of the patient population was uncharacteristically low for nursing homes, e.g., 46 years. IL Review Report.

2. Discussion of the Issues in Illinois

Illinois expended most of its effort in this case arguing general legal issues. To the extent the presentation related peculiarly to Illinois, it related primarily to State policy and to the characteristics of all Illinois ICFs rather than to the specific facilities found to be IMDs.

Illinois attacked the Agency criteria in general and the use of patient diagnosis in particular, presenting testimony on the dangers of patient labeling. Illinois also submitted evidence designed to show that its facilities certified as ICFs are distinguishable from State psychiatric hospitals. We have addressed these issues above.

With respect to the specific findings in Illinois, the State presented evidence primarily on three points: the legal requirements governing admission and discharge policies of Illinois ICFs; the nature of follow-up responsibility by the Illinois Department of Mental Health for patients in the facilities; and the significance of placement of patients from State mental facilities into these ICFs. We do not find that any of this evidence overcomes the Agency's findings as to the overall character of the specific facilities as IMDs.

Illinois has established that State regulations governing admission and discharge policies of ICFs expressly prohibit the admission or retention of persons who require "mental treatment" as defined in the Illinois Mental Health Code. That definition, however, refers to a person needing "mental treatment" if "that person is afflicted with a mental illness and as a result of such mental illness is reasonably expected . . . to intentionally or unintentionally physically injure himself or other persons, or is unable to care for himself so as to guard himself from physical injury or to provide for his own physical

needs." IL Hearing Exhibit 5. Thus, need for "mental treatment" can certainly not be equated in Illinois with being mentally ill. In addition, the policies of the Illinois State Psychiatric Institute, a recognized IMD, indicate that a person might be discharged from a psychiatric hospital providing "mental treatment" into a long-term care facility "because of continuing illness, which has proved refractory to all available therapies which the hospital has to offer." IL Hearing Exhibit 2, p. 6.

Moreover, the admission policy of Grasmere Residential Home, Inc., one of the ICFs involved here, indicates that, while the Home did not provide "mental treatment," it did consider itself as providing some form of treatment to patients where therapeutically indicated. IL Hearing Exhibit 3.

Illinois also presented testimony regarding the scope of the jurisdiction of the Illinois Department of Mental Health and Developmental Disabilities. According to the Director of the Department, who testified at the hearing, the Department has jurisdiction only over the mentally ill in hospitals. Follow-up responsibility for persons placed from hospitals into facilities such as these ICFs does not include monitoring of individual patients, only evaluation of the patients' status as affected by the facilities programs. Tr., p. 301. The Department merely acts as an advocate for persons discharged from State mental health facilities. Tr., p. 284. Based on this, the State argued that the Agency should not have placed any significance on the fact that the Department had follow-up responsibility for a number of the patients placed in the ICFs here. IL Reply Br.

Illinois' evidence on this point is convincing to show the scope of the Department of Mental Health's jurisdiction and the nature of its follow-up responsibility. We would also agree that the fact of follow-up responsibility does not necessarily indicate continuing mental illness. However, Illinois has not demonstrated that patients for whom the Department had that responsibility were considered cured and were placed into these ICFs for purely physical illnesses. Indeed, the Agency's evidence shows that most of the patients were ambulatory and few had physical problems. Thus, while we do not consider the fact that the Department had follow-up responsibility for a

number of the patients placed in the facilities here to have great weight, we nonetheless consider it some support for the general finding that high percentages of the patients were mentally ill.

The remainder of Illinois' evidence is intended primarily to show that the placement of patients from State mental facilities into these ICFs does not mean these facilities were used as alternatives to the State facilities. In addition to pointing to Illinois regulations on persons requiring "mental treatment," discussed above, Illinois presents evidence to show: 1) persons placed in ICFs are placed there solely because they need the care that an ICF normally provides, Tr., p. 283-287; 2) only a small percentage of persons discharged from State facilities were placed in long-term care facilities during the disallowance period, IL Hearing Exhibit 6; and 3) the Department of Mental Health has placed persons in approximately 400 different facilities during the disallowance period, Tr., p. 291.

The Agency has not rebutted these points, and Illinois' evidence does indicate, at least, that the State was not arbitrarily "dumping" patients from State mental hospitals into ICFs, using them as inappropriate alternatives to mental hospital care. The real issue here, however, is whether particular facilities were IMDs. As part of its findings supporting the conclusion that the facilities had the requisite overall character, the Agency found that the facilities had relatively large numbers of patients placed into the facilities from State mental hospitals. None of the State's evidence directly contradicts the Agency's findings, which are based on State census reports. Indeed, given that only small percentages of persons discharged from State facilities were placed in long-term care and that over 400 facilities received some patients, the relatively high number of placements into these facilities has greater weight in showing that these facilities were not typical ICFs than it would otherwise.

Thus, while we find Illinois' evidence sufficient to establish certain facts, those facts are not directly relevant to the issues before us and do not overcome the Agency's findings that high percentages of the patients in the facilities had mental disorders and that the State in some way recognized that the facilities

were primarily serving the mentally ill. Thus, we conclude that the facilities met the regulatory definition and were IMDs.

Accordingly, we sustain the disallowance of \$4,261,162 in FFP claimed for services provided in these facilities.

C. Minnesota

Docket Nos. 79-52-MN-BC and 79-89-MN-BC involve disallowances of FFP claimed by the State of Minnesota for services provided to persons under 65 years of age in three ICFs during quarters ending September 30, 1977 through June 30, 1978. The Agency concluded that the three facilities were IMDs based on a review conducted by the Region V Medicaid Bureau.³² The Agency states that these facilities were selected for review based on a list of facilities with a Minnesota "Rule 36" license for residential facilities providing programs for five or more mentally ill persons. The record indicates, however, that only two of the three facilities had this type of license. MN Review Report, Attachment 8.

1. The Reviewers' Findings in Minnesota

Utilizing methods similar to that employed by the Illinois review team, the reviewers examined Minnesota Department of Public Welfare records that included judgments by the State's medical personnel as to the primary reason for each Medicaid patient being in the facility. Diagnoses of mental diseases were based on the ICDA. The reviewers also considered correspondence from the facilities, statements by Minnesota concerning the facilities, and other information.

The reviewers concluded that all three facilities were "primarily engaged in providing treatment and care for persons with mental diseases." The findings for individual facilities are described below.

Andrew Care Home

90.4% of the Medicaid patients in this facility were found to have diagnoses of mental diseases. In a letter to the Agency

³² "Report on Review of Federal Financial Participation under Medicaid in Payments for Care in Institutions for Mental Diseases," November 8, 1978 (MN Review Report).

concerning a requested waiver of a handrail requirement, counsel for the home characterized it as follows:

"... the residents of Andrew Care Home are handicapped because of mental health rather than physical disability"

"... only 10% of the total resident population is over 65 years old"

"The majority of residents of the facility carry a diagnosis of schizophrenia or paranoid schizophrenia or other neurological disorders." MN Review Report, Attachment 10.

In a subsequent letter, the same law firm referred to Andrew Care Home as a "mental health residential facility." MN Review Report, Attachment 11. According to State records cited by the reviewers, the average age of Medicaid patients in the facility in November 1977 was 39.88 years. Andrew Care Home was licensed under Rule 36 from December 1, 1976 to January 1, 1978 and the review report quotes the following statement, concerning the license, made in a memorandum of the Minnesota Department of Public Welfare:

Rule 36 licensure is a direct admission, being a program license, that the facility has a fairly primary intent to provide specific care and treatment aimed at the mentally ill population.

Birchwood Care Home

86.4% of the Medicaid patients in this facility were found to have diagnoses of mental diseases. The Minnesota Department of Public Welfare in a letter dated December 27, 1977 stated that the average age of Medicaid residents in November 1977 was 58 years. Birchwood Care Home had a Rule 36 license for adult mentally ill persons from March 1, 1977 to March 1, 1978.

Hoikka House

The reviewers found that 94.9% of the Medicaid patients in this facility had diagnoses of mental diseases. The average age of Medicaid patients in November 1977 was 48 years and a

majority of patients came to the house from State hospitals. A calling card of the Hoikka House program director refers to the facility as providing "Care of the Mentally Ill."

2. Discussion of the Issues in Minnesota

a. Availability of Psychiatric Treatment and Diagnostic Services on the Premises

Minnesota argues that the Agency criteria failed to address a critical element of the definition of an IMD by failing to consider the availability of psychiatric treatment at the facilities. Minnesota presented affidavits from administrators of all three facilities, stating that residents did not receive psychiatric or psychological services on the premises of the facility. Any such services received by the patients were furnished outside the facility. The administrators characterize the services provided by the facilities as counseling in "basic living skills" designed to increase patients' capacity to function more independently and to deal with daily living needs.

As we discussed more fully in our section on the regulations, the regulatory definition of an IMD requires that a facility provide "treatment" for its patients, not a specific kind of treatment such as active psychiatric services. The Agency argues that, depending on the individual's condition, counseling in living skills may be just as significant in treating the individual as classic psychiatric therapy. Further, Minnesota does not deny that psychiatric treatment received by residents outside the facilities may complement the services received within the facility and may be considered to be part of the residents' comprehensive treatment program at the facility.

Minnesota also argues that the Agency's criteria are defective in that they do not consider the availability of diagnostic services at the facilities. We have previously addressed several aspects of this issue. The regulations do not require that a facility must provide diagnostic services for mental diseases in order to be classified as an IMD. Moreover, Minnesota has not presented evidence that the facilities here do not diagnose patients upon admission or at some subsequent time.

b. Recorded Diagnoses of Patients as an Indication of Type of Facility

Minnesota also argues extensively that the recorded diagnoses of the patients are not a reliable indicator of the type of facility since misdiagnosis frequently occurs and old diagnoses are not updated. Minnesota adds that the listing used for classifying mental diseases, the ICDA, is indefinite and of limited usefulness. Minnesota ignores the fact, however, that the diagnoses cited here were derived from the State's own records and were used by health professionals in placing and retaining the residents in the facilities under review. Regardless of whether the diagnoses were correct, the facilities apparently depended on them in providing patient treatment and care and in developing their services and programs. Moreover, it would be unreasonable to require the Agency to rediagnose each of the individuals in the facilities under review merely so it could administer the IMD provisions. While Minnesota criticizes the ICDA for lack of definiteness, it does not propose any preferable alternative method of classification.

Minnesota also argues that the key specialist that assisted in the Agency review lacked the background to assess the facilities and to evaluate patient diagnosis. As we understand the review procedures, however, the specialist depended largely on the State's own records. Minnesota does not allege that the statistics cited were inaccurately transcribed. Also, the Agency alleged that its reviewers were assisted by medical personnel when necessary and the State has not disputed this.

c. Other Arguments

The State also raises a series of arguments concerning individual criteria applied by the Agency. The Agency has never asserted that age distribution, former place of treatment, or Rule 36 licensure, if taken alone, would be a decisive indication of the facility's character. The Agency may properly consider these criteria, in our view, if it also considers more conclusive ones such as the facility's own representations and the makeup of the patient population. We certainly would not discount representations made by the facility's counsel relating

to another Medicaid program requirement simply because the facility could "benefit" from the representation.

In conclusion, there is substantial evidence in the record that these facilities met the regulatory definition for IMDs. A very large percentage of the patient population in each of the facilities had diagnoses of mental diseases, and other significant indicators support the Agency's findings in each case. While Minnesota has raised legal arguments concerning the weight to be given to findings, it has not presented any evidence to persuade us that these findings were incorrect.

Accordingly, we sustain the disallowance of \$896,159 in FFP claimed for these facilities during quarters ending September 30, 1977 through June 30, 1978.

D. California

Docket No. 80-184-CA-HC involves a disallowance of FFP claimed by the State of California for services provided to persons under 65 years of age in five SNFs during the quarters ended March 31, 1975, through September 30, 1977. Based on an HHS Audit Agency report,³³ the Agency determined that the five facilities were IMDs.

In classifying the facilities as IMDs, the Agency primarily relied on four factors: participation by the facilities in a special State program for the mentally disordered; licensing status; program and admission policies; and patient population. Below we discuss each of these factors, as well as some general arguments the State makes. We conclude that the Agency has presented substantial evidence to show that these California SNFs were IMDs.

1. The Special Disabilities Service Program

In September 1974, the State of California authorized funding for a Special Disabilities Service (SDS) Program, through which a supplemental payment could be made to

³³ "Audit of Five Selected Skilled Nursing Facilities that Participated in California's Special Disabilities Services Program for the Mentally Disordered, February 1, 1975, through September 30, 1977," ACN 00150-09 (CA Audit Report), Exhibit A to CA Supp. to App.

participating SNFs and ICFs for services to persons who were developmentally disabled, substance abusers (alcohol or drugs), or mentally disordered. California Administrative Code, Title 22, Division 5. In order for a facility to be certified for the mentally disordered component of the SDS Program, at least 30 of its patients had to be certified by the local mental health director as having a primary or secondary diagnosis of a mental disorder. CA Audit Report, p. 12. Participation in the SDS Program was used by Agency auditors as an initial screening device in choosing the five facilities in question here.

California does not deny that each of the facilities participated in the program, but attempted to show that it was irrelevant to IMD status. Through testimony, California implied that the fact of participation might be misleading since the SDS Program served the developmentally disabled and substance abusers, as well as the mentally disordered. Tr., pp. 258-262. As part of the administrative record on which it based its decision (Agency Record), however, the Agency has submitted materials which show that each of these facilities qualified for a component of the program called "mentally disordered rehabilitation," and that some of the facilities had more eligible patients than the required number.³⁴ Agency Record, Tab 16. The State has not challenged the authenticity of these documents. These materials also show that both the facilities and the State referred to the program as a "special treatment" program. This undermines the State's position that the rehabilitation services provided should not be considered "treatment" within the meaning of the IMD regulatory definition.

b. Licensing Status

Another factor relied upon by the Agency auditors in determining IMD status was that the facilities were licensed by the State as skilled nursing facilities, "long-term mental." A California witness testified that this license classification (re-

³⁴ We do not think it significant that all of the patients were not eligible since the materials indicate that ineligibility may relate to lack of rehabilitation potential rather than to mental status.

ferred to as an "L-facility") was developed for "wandering geriatrics," and some people therefore thought the "L" referred to permission to have a locked door. Tr., pp. 225-226. Yet, the relevant licenses clearly say "long-term mental," and indicate for some facilities that the total bed capacity had that classification and for others that at least half the capacity did. Agency Record, Tab 16.

2. Program and Admission Policies

For their conclusion that the facilities were established and maintained primarily for the care and treatment of persons with mental diseases, the auditors also relied heavily on the facilities' program and admission policies. Some of the most significant statements in these materials, included in the Agency Record at Tab 16, are the following:

Facility A:

This facility was self-described as having cared for "over 1000 mentally disabled residents" during its 4 and ½ years of experience. Its program was described as "a practical approach at teaching/reteaching the skills of living required for the severely mentally disordered." Patient profiles included "treatment" as the "functional level" which "includes the majority of residents." The program was described as a standard one, varying only "according to the specific patient's treatment plan." A Certification and Transmittal form for Medicaid eligibility of the facility identified as the "certification specialization and/or services" of the facility "mentally disordered/rehabilitation."

Facility B:

Its own Program Philosophy described this facility as a "120 bed facility comprised primarily of mentally ill patients." An Information Booklet describing participation of the facility in the SDS Program stated that the extra funding "is expended strictly on additional psychiatric and recreational staff members" Under "Admission Policies" is the following: "Only patients in need of 24 hour skilled nursing services for the management and observation of mental illness or other related behavioral disorders shall be admitted Patients with only physical illnesses shall not be admitted."

Facility C:

The admission policy of this facility was described as an intent "to admit patients who exhibited behavior compatible with the State's Special Treatment Program." The philosophy of the facility was "to care for those individuals who have a mental disorder requiring long-term care in a highly structured, secure environment," and the basic program was described as "utilization of behavioral intervention and rehabilitation techniques."

Facility D:

Facility materials referred to "residents of our long-term psychiatric facilities." Program philosophy was described as "employment of all the latest, medically approved psycho-social treatment modalities." The facility also had "mentally disordered/rehabilitation" as a certification status.

Facility E:

The admission policy of this facility was to exclude "patients that do not have a primary psychiatric diagnosis." The treatment program was described as "planned for the chronically mentally ill, not the mentally retarded."

California attacked the reliability of this evidence through testimony that it would be to a facility's financial advantage to advertise as a facility specializing in the mentally ill so as to qualify for the SDS Program. Tr., p. 223. We are not inclined on this basis, however, to conclude that these facilities misrepresented themselves, particularly since some of their statements were not purely advertising but related to certification for State programs.

3. Patients' Diagnoses

The points on which California did present some persuasive evidence mostly went to the issue of whether the auditors' findings were reliable with respect to diagnoses of the patients.

The auditors described their method for determining the characteristics of the patient populations of the five SNFs as follows:

We randomly selected 210 Medicaid claims for each of the five SNFs, or 1,050 sample items in total, for the periods the SNFs participated in the [SDS] Program until September 30, 1977. We then made on-site visits to the five SNFs and reviewed patients' medical records for the periods covered by the paid claims. We obtained the patients' primary and secondary diagnoses and noted if the patients were being treated for physical illnesses or mental diseases. We categorized the patients' diagnoses as mental diseases based on those listed under the heading of Mental Disorders in the [ICDA].

* * *

Our review showed that 1,005, or 95.7 percent, of the claims were for patients with mental diseases and 45, or 4.3 percent, of the claims were for patients who had physical illnesses as their primary diagnoses. CA Audit Report, pp. 15-16.

The auditors' charts show that the auditors included as primary diagnoses of mental diseases the categories alcoholism, schizophrenia, chronic/organic brain syndrome, senility, psychosis, and "other mental diseases." CA Audit Report, pp. 16-17.

California attacks these findings on a number of different grounds, challenging the reliability of the findings as a whole, the specific inclusion of certain diagnoses as mental, and the use of medical records.

California's position is most fully elaborated in a report prepared by a clinical psychologist who is a Senior Mental Health Consultant for the State (Consultant).³⁵ In her report and testimony at the hearing, this Consultant assessed the results of a study, performed at the request of the State,

³⁵ "Assessment of the Diagnostic Composition of the Patient Population in a SNF Deemed by Federal Auditors To Be an IMD: Further Analysis of Results and Implications for Interpreting the Audit Approach and Findings," Exhibit C to CA Supp. to App. (Consultant's Report).

designed to provide accurate diagnostic characterization of the patients in one of the five SNFs audited (Diagnostic Study).³⁶

The Consultant challenges the auditors findings that 95.7% of the sample claims were for patients with mental diseases and only 4.3% were for patients with a primary diagnosis of physical illness. She states: "These proportions strikingly differ from those which would be anticipated on the basis of well-documented, methodologically sound studies of the extent of primary physical diseases in patient populations manifesting mental symptoms." Consultant's Report, p. 47. For this proposition, the Consultant relies on the Diagnostic Study mentioned above and on a "landmark study" which showed a 46% error rate of undiagnosed primary physical disorders in a group of 100 State hospital psychiatric admissions.³⁷

While California presents convincing evidence to the effect that misdiagnosis of patients with mental symptoms is prevalent, we are not persuaded that we should therefore apply the 46% error rate to the auditors' findings, as California suggests.

Even though the Agency may have been relying on diagnoses in patients' records which were incorrect, to the extent that these diagnoses were in the records, they are evidence as to the "overall character" of the facilities. The facilities were admitting and treating the patients using those diagnoses. The Agency cannot be expected to perform for each patient the extensive diagnostic analysis which California's own evidence shows is necessary to properly determine whether there is a physical cause of psychiatric symptoms. Moreover, the "landmark study" on which California partially bases its thesis that many of these SNF patients were misdiagnosed is a study of patients in a *State mental hospital*. Therefore, misdiagnosis is hardly a basis for distinguishing these SNFs from recognized IMDs.

³⁶ "Neurobehavioral Evaluation and Diagnostic Study of 102 patients in an 'L' Facility", prepared by Neurobehavioral Foundation, Exhibit B to CA Supp. to App.

³⁷ "Physical Illness Manifesting in Psychiatric Disease," Hall et al., reprinted in Consultant's Report.

California's Consultant also presents a detailed analysis to show that the auditors did not properly apply the ICDA in classifying patients. The most cogent evidence of this which California presents relates to the categories of senility, alcoholism, and chronic/organic brain syndrome. The State presented expert testimony by a psychiatrist with the California Department of Mental Health (Psychiatrist), who pointed out the difficulties associated with use of the ICDA. He testified that "senility" is not a code in the mental disorders chapter of the ICDA. Tr., p. 183; see also, Consultant's Report, p. 50. California also questioned the auditors' use of the term "alcoholism." According to California's Consultant, there is a code in the ICDA for "alcoholism," meaning either episodic or habitual excessive drinking, as well as a code in the mental disorders chapter for "alcoholic psychoses," which come within the organic mental disorders. Consultant's Report, p. 50. With respect to the category "chronic/organic brain syndrome" (which the Psychiatrist describes as a constellation of symptoms which raises the suspicion that something has gone wrong with the brain itself, Tr., p. 203), California states that the ICDA guidelines require that patients with any organic mental disorder also be coded for the causal or associated physical disease. Consultant's Report, pp. 51-52; Tr. pp. 184, 190. Thus, California concludes that the auditors misused the ICDA.

The Agency did not present any evidence which would show that senility should have been included as a mental disease, although testimony by California's Psychiatrist suggests that this would not always be inappropriate. Tr., p. 183. The Agency also did not fully explain its rationale for inclusion of alcoholism and chronic/organic brain syndrome here. But see, CT Review Report, Attachment F.

The record shows that the State's underlying factual premises have some validity. We do not agree with the State, however, as to the conclusions to be drawn from those premises. California acknowledges that many persons whose diagnoses were senility, alcoholism, or organic brain syndrome were in State mental hospitals in the early sixties. Tr. pp. 116-117; see also, Tr. p. 193. Moreover, even if we were to exclude

patients with these primary diagnoses on the grounds that including them was inconsistent with proper use of the ICDA, the auditors' sample still provides a basis for concluding that over 50% of the patients had mental diseases. Out of the 210 sample claims for each facility, patients placed by the auditors in the categories of schizophrenia, psychosis, and "other mental" total well over 50% of the claims. Excluding the "other mental" category as well would reduce the percentage of patients with primary mental disorders below 50% for one of the facilities only (Facility B). CA Audit Report, p. 17.

We consider it most important, however, that any defects in the auditors' findings here must be viewed in the context of other strong evidence that the facilities had the requisite "overall character." In particular, the facilities' own program and admission policies discussed above support the finding that the facilities were primarily engaged in treating persons with mental diseases.

4. Other Arguments by California

The State also attempts to show the unreliability of medical records for determining diagnosis and the need for exercise of medical judgment where there is more than one diagnosis. As we have previously mentioned, we think the Agency was reasonable in relying on medical records under these circumstances. Also, while the auditors here certainly do not have the credibility that the Connecticut review team had, the Agency has stated without contradiction that the auditors were advised by a physician-consultant whenever necessary and, in cases of doubt, the audit team would confer with the medical staff of the facility. Cons. Br., p. 9.

We also conclude that the State's remaining arguments do not have merit. The State points out that private-pay patients were not included in the auditors' sample, but has presented nothing to lead us to conclude that the characteristics of these patients would be significantly different from those of the Medicaid patients. This is highly unlikely in view of the facilities' program and admission policies. The State also argued at one point that the auditors presupposed their result and did not do a random sample of all the facilities participating in the SDS Program. The Agency responded that the audit

was performed in accordance with generally accepted principles, that the auditors did not have a "preconceived purpose," and that there was no need for a random sample of all participating SNFs since the disallowance relates to only five of them. Agency Response, Docket No. 80-184-CA-HC, pp. 27-28. California did not press its arguments on these points during the later stages of the proceedings, and we do not find them convincing.

5. Conclusion in California

California has shown that there might have been some defects in the audit here, notably the inclusion of patients with senility. The evidence as a whole, however, convincingly demonstrates that these five facilities had the "overall character" of being IMDs.

Accordingly, we sustain the disallowance of \$2,329,401 claimed by the State of California for services provided by these facilities in the quarters ending March 31, 1975 through September 30, 1977.

VI. General Conclusion

For the reasons stated above, we uphold the Agency disallowances in all five appeals considered jointly here.

/s/ Cecilia Sparks Ford
Cecilia Sparks Ford

/s/ Donald F. Garrett
Donald F. Garrett

/s/ Norval D. Settle
Norval D. (John) Settle,
Panel Chair

le

APPENDIX E

No. 82-1164 and 82-2297

No. 82-1164

STATE OF MINNESOTA, BY ITS COMMISSIONER OF
PUBLIC WELFARE, ARTHUR E. NOOT,
Petitioner,

v.

MARGARET M. HECKLER, SECRETARY, AND THE UNITED STATES
DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Respondents.

No. 82-2297

STATE OF MINNESOTA, BY ITS COMMISSIONER OF
PUBLIC WELFARE, ARTHUR E. NOOT,
Appellee,

v.

MARGARET M. HECKLER, IN HER OFFICIAL CAPACITY AS
SECRETARY OF THE UNITED STATES
DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Appellant.

Appeal from the United States District Court
for the District of Minnesota.

**Petition for Review of Order of Secretary of
Department of Health and Human Services.
Filed: September 30, 1983**

Submitted: November 8, 1982
Filed: September 30, 1983

Before LAY, Chief Judge, ROSS and FAGG, Circuit Judges.

LAY, Chief Judge.

These cases were consolidated for purposes of resolving issues of subject matter jurisdiction and conflicting interpretations of Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (1976 & Supp. V 1981). The State of Minnesota contests a decision of the Secretary of the United States Department of Health and Human Services (HHS) disallowing federal financial participation to the State under the Medical Assistance Program (Medicaid) for costs incurred in three community residential facilities. The facilities were determined by the Secretary to be "institutions for mental diseases" (IMDs) and thus were not qualified for partial federal reimbursement of medical costs for individuals eligible for Medicaid.

Beginning in 1973, the State of Minnesota paid Medicaid claims for individuals receiving services in the Andrew Care Home, the Birchwood Care Home, and the Hoikka House. The three community residential care homes had been certified as "intermediate care facilities" (ICFs).¹ "Intermediate care facility services" for eligible individuals under 65 are reimbursable under the Act other than such services provided in an institution for tuberculosis or an "institution for mental diseases." See 42 U.S.C. § 1396d(a)(15), (18)(B) (1976). The residents of these three homes included a majority of individuals with mental illness diagnoses. During the quarters ending September 30, 1977 through June 30, 1978, Minnesota claimed and was paid \$896,159 in federal financial participation for services provided to the Medicaid recipients at these three facilities. In November 1978 the HHS Health Care Financing Administration (HCFA) submitted an audit report which recommended disallowance of the \$896,159 claim on the ground that these facilities were IMDs. The agency employed unpublished interpretive guidelines to determine if the "overall character" of the facilities fit the regulatory definition of an IMD as being "primarily engaged in providing diagnosis, treatment or care of persons with mental diseases." See 42 C.F.R. § 435.1009(e) (1982); see also *id.* § 440.140(a)(2) (1982). As a result, the Secretary disallowed the State's claim.

¹ In 1982 over 600 Minnesota facilities were certified as "intermediate care facilities."

The State petitioned the HHS Departmental Grant Appeals Board for a review of the decision. Consolidating the petition with requests by the States of Connecticut, California, and Illinois to review similar disallowances, the Board upheld the agency decision. Departmental Grant App. Bd. Nos. 79-52-MN-HC, 79-89-MN-HC, 80-44-IL-HC, 80-150-CT-HC, 80-184-CA-HC (Nov. 30, 1981). HHS recovered the full amount of these funds paid to Minnesota by offsetting federal financial participation in a supplemental grant to the State.

Minnesota filed a petition for direct review of the final agency order with this court; such action was taken to protect the right of review in the event the dispute was determined to be a plan conformity matter under 42 U.S.C. § 1316(a)(3) (1976 & Supp. V 1981),² and not a disallowance under 42 U.S.C. § 1316(d) (1976 & Supp. V 1981).³ The State also

² 42 U.S.C. § 1316(a)(3) (1976 & Supp. V 1981) reads in relevant part:

Any State which is dissatisfied with . . . a final determination of the Secretary under section . . . 1396c of this title may, within 60 days after it has been notified of such determination, file with the United States court of appeals for the circuit in which such State is located a petition for review of such determination.

For operation of state plans, 42 U.S.C. § 1396c (1976) states:

If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this subchapter, finds—

(1) that the plan has been so changed that it no longer complies with the provisions of section 1396a of this title; or

(2) that in the administration of the plan there is a failure to comply substantially with any such provision;

the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

³ 42 U.S.C. § 1316(d) (1976 & Supp. V 1981) reads as follows:

(d) Whenever the Secretary determines that any item or class of items on account of which Federal financial participation

(footnote continues)

sought review of the Board's decision in the United States District Court for the District of Minnesota by filing an action for declaratory and injunctive relief as well as restoration of its grant money withheld by HHS.

The district court granted summary judgment in favor of the State of Minnesota, holding that HHS acted arbitrarily, capriciously, and outside the scope of its authority; it ordered HHS to return to the State the disallowed funds. *Minnesota v. Schweiker*, No. 4-82-155, slip op. at 14 (D. Minn. Aug. 25, 1982). HHS now appeals this decision. The two cases were consolidated to resolve the jurisdictional issues and the merits.

I. Plan Conformity or Disallowance.

A fundamental question is whether this dispute involves a noncompliance question or a disallowance. Both the Secretary and the State urge that the matter involves a disallowance and therefore this court has no jurisdiction to directly review the Board's decision. We agree.

Recent decisions from other circuits have taken divergent approaches to assessing the nature of Medicaid controversies. The First Circuit employs a functional analysis which examines three criteria: (1) whether the matter could comfortably fit within the plan conformity language of 42 U.S.C. § 1396c (1976); (b) whether the broad nature of the dispute points to characterization as a conformity issue; and (3) what procedures and label the Secretary has chosen, "not as definitive but as entitled to some respect." See *Massachusetts v. Departmental Grant Appeals Board*, 698 F.2d 22, 27-30 (1st Cir. 1983). Cf. *New Jersey v. Department of Health and Human Services*, 670 F.2d 1262, 1272 (3d Cir. 1981) (*New Jersey I*) (court must independently evaluate underlying substance of dispute so that court of appeals' jurisdiction is not contingent upon Secretary's unfettered discretion); *State Department of Public Welfare v. Califano*, 556 F.2d 326, 330 (5th Cir. 1977), cert. denied, 439

(footnote continued)

is claimed under title . . . XIX . . . , shall be disallowed for such participation, the State shall be entitled to and upon request shall receive a reconsideration of the disallowance.

U.S. 818 (1978) (court should review Social Security Act, legislative history, and circumstances of claim to see what label best serves purposes of the act and the equities of the situation).

In contrast, the Seventh Circuit found the functional approach "complicated and therefore uncertain in application—a serious weakness in a jurisdictional test." *Illinois v. Schweiker*, 707 F.2d 273, 278 (7th Cir. 1983). Instead, it adopted a literal test which allows HHS' choice of the plan conformity or disallowance label and procedures to control.⁴ *Id.* Cf. *Connecticut v. Schweiker*, No. 82-4023 (2d Cir. April 20, 1982) (without explanation, court of appeals dismissed for lack of jurisdiction a petition for direct review of alleged plan conformity issue; Secretary had denominated the dispute as a disallowance); *Department of Public Health v. Departmental Grant Appeals Board*, No. 81-3341 (6th Cir. Nov. 4, 1981) (same); *Washington Department of Social and Health Services v. Schweiker*, No. 81-7414 (9th Cir. Sept. 30, 1981) (same).⁵

Although some deference is to be accorded the Secretary's opinion on these jurisdictional fact issues, we find the functional test in *Massachusetts v. Departmental Grant Appeals Board*, 698 F.2d at 27-30, is more in accord with the traditional role of federal judicial review which mandates judicial inquiry as to congressional intent, jurisdiction, and the legality of federal administrative actions. Accord *New Jersey I*, 670 F.2d at 1272.

The underlying nature of this controversy stems from the discrete reason that three nursing homes were decertified and thus did not qualify for federal funding. In this regard, the district court correctly observed "[t]his dispute does not concern the validity of Minnesota's Medicaid plan or its overall

⁴ The Seventh Circuit panel did interject a caveat to its "clean line" approach, noting that some "safety valve" may be necessary to prevent HHS from evading the scheme of judicial review created by Congress when the practical effect of a disallowance is to shut off all or most of a state's federal financial participation. *Illinois v. Schweiker*, 707 F.2d at 279.

⁵ In *Illinois v. Schweiker*, the court stated that it prefers "the simpler approach apparently followed by the Sixth and Ninth Circuits" in these cited cases (emphasis added). The court acknowledged that "the Third Circuit has questioned the meaning of these cryptic unpublished orders." *Illinois v. Schweiker*, 707 F.2d at 279. See also *New Jersey I*, 670 F.2d at 1273 n.10.

administration." *Minnesota v. Schweiker*, slip op. at 4-5. Plan conformity issues under the statute, sections 1316(a)(3) and 1396c, generally relate to compliance questions that have a broad impact on the overall state program. We cannot say, under the plan conformity specifications of section 1396c(2), that the State in the administration of its Medicaid plan failed to comply substantially with the provisions of 42 U.S.C. § 1396a (1976 & Supp. V 1981). The decertification here is basically rooted in a failure to comply with an agency interpretive guideline.⁶ In addition, the claim arises out of the disallowance procedures involving a specific audit, and only a retroactive, not prospective, sanction was imposed.⁷ We thus conclude that the dispute clearly relates to a disallowance rather than a conformity issue. *Accord Connecticut v. Schweiker*, No. 82-4023 (2d Cir. Apr. 20, 1983); *Connecticut v. Schweiker*, 557 F. Supp. 1077, 1079 & n.5 (D. Conn. 1983).

II. Jurisdiction of District Court.

Although section 1316(a) (3) grants a state dissatisfied with a plan conformity decision the right to direct review in a court of appeals, the provision for disallowances, section

⁶ It is unclear under 42 U.S.C. § 1396 (1), (2) (1976) whether a plan conformity issue can pertain not only to a state's substantial failure to comply with a federal statutory plan requirement, 42 U.S.C. § 1396a (1976 & Supp. V 1981), but also to a state's substantial failure to comply merely with a federal regulation or the state's own plan. *Massachusetts v. Departmental Grant Appeals Board*, 698 F.2d at 28-29 & nn. 5 & 7. HHS has specified that a plan conformity issue may arise from the failure of a state in practice to comply with "a Federal requirement." 45 C.F.R. § 201.6(a) (1982). Compare *Department of Public Health v. Departmental Grant Appeals Board*, No. 82-3760, slip op. at 2 (6th Cir. May 9, 1983) (disallowance, not conformity issue, found; state in "non-compliance with regulatory rather than statutory requirements") with *New Jersey I*, 670 F.2d at 1266-77 (plan conformity issue found although noncompliance was only with a federal requirement in a "program instruction"); and *Solomon v. Califano*, 464 F. Supp. 1203, 1206-08 (D. Md. 1979) (plan conformity found although noncompliance was only with state's plan).

⁷ Administrative procedures governing federal audit agency issues are set forth in 45 C.F.R. § 201.10-.66 (1982).

1316(d), is silent as to the availability of judicial review for such disputes.⁸

We agree with the courts that have found that disallowance decisions under section 1316(d) are judicially reviewable. *Illinois v. Schweiker*, 707 F.2d at 275-277; *Alameda v. Weinberger*, 520 F.2d 344, 347-48 (9th Cir. 1975); *Colorado Department of Social Services v. Department of Health and Human Services*, 558 F. Supp. 337, 347-48 (D. Colo. 1983); *Connecticut v. Schweiker*, 557 F. Supp. at 1079. Cf. *Solomon v. Califano*, 464 F. Supp. 1203 (D. Md. 1979) (court reviewed disallowance decision without discussing jurisdiction); *Georgia v. Califano*, 446 F. Supp. 404 (N.D. Ga. 1977) (same). *Contra State Department of Public Welfare v. Califano*, 556 F.2d 326, 329 n.4, 332 (5th Cir. 1977), cert. denied, 439 U.S. 818 (1978) (dictum).

Although the district court has jurisdiction to review this disallowance, the court's power is limited to granting prospectively-oriented declaratory relief. We must vacate the district court's money award restoring past disallowance funds since jurisdiction for this claim is exclusively in the United States Claims Court.⁹

The exclusive jurisdiction of the Claims Court applies to monetary claims in excess of \$10,000 against the United States and its agencies. 28 U.S.C. § 1491 (1976 & Supp. V 1981).¹⁰ Since 1972, the Claims Court also can grant limited equitable relief collateral to a monetary award in order to resolve an

⁸ HHS does not contest the district court's jurisdiction to review a disallowance decision. It has previously taken an opposite position. See *Alameda v. Weinberger*, 520 F.2d at 347-48.

⁹ We raised the issue sua sponte whether exclusive jurisdiction over both monetary and nonmonetary claims lay in the United States Claims Court.

¹⁰ 28 U.S.C. § 1491 (1976 & Supp. V 1981) states in relevant part:

The Court of Claims shall have jurisdiction to render judgment upon any claim against the United States founded either upon the Constitution, or any Act of Congress, or any regulation of an executive department, or upon any express or implied contract with the United States, or for liquidated or unliquidated damages in cases not sounding in tort. . . . To provide an entire remedy

(footnote continues)

entire controversy. *See id.*; *Polos v. United States*, 556 F.2d 903, 906 (8th Cir. 1977); *Melvin v. Laird*, 365 F. Supp. 511, 516-20 (E.D.N.Y. 1973).

If the declaratory or injunctive relief a claimant seeks has significant prospective effect or considerable value apart from merely determining monetary liability of the government, the equitable relief sought is paramount and the district court may assume jurisdiction over the nonmonetary claims.¹¹ *See Giordano v. Roudebush*, 617 F.2d 511, 514-15 (8th Cir. 1980);

(footnote continued)

and to complete the relief afforded by the judgment, the court may, as an incident of and collateral to any such judgment, issue orders directing restoration to office or position, placement in appropriate duty or retirement status, and correction of applicable records, and such orders may be issued to any appropriate official of the United States. In any case within its jurisdiction, the court shall have the power to remand appropriate matters to any administrative or executive body or official with such direction as it may deem proper and just.

Cf. 28 U.S.C. § 1346(a)(2) (1976 & Supp. V 1981) (district court has concurrent jurisdiction to grant monetary relief on claims under \$10,000).

¹¹ A split of authority exists on the issue whether the district court can assume jurisdiction over equitable claims based on the same facts as monetary claims when the Claims Court also has the power to grant the nonmonetary relief. Some courts, including this circuit, have found the equitable jurisdiction of the district court concurrent with the Claims Court when the nonmonetary relief is deemed "primary." *See, e.g., Giordano v. Roudebush*, 617 F.2d 511, 515 (8th Cir. 1980); *Stanley v. Commissioners*, 505 F. Supp. 63, 65 (W.D. Mo. 1980); *Bruzzone v. Hampton*, 433 F. Supp. 92, 95-96 (S.D.N.Y. 1977); *Melvin v. Laird*, 365 F. Supp. at 518. *But cf. Keller v. Merit Systems Protection Board*, 679 F.2d 220, 223 (11th Cir. 1982) (distinguished *Giordano* because monetary claim was less than \$10,000 at time complaint was filed and thus was within district court's statutory jurisdiction). This approach is supported by legislative history indicating that the grant of collateral equitable jurisdiction to the Claims Court in 1972 was intended only to provide an alternative option for litigants to obtain complete relief in one court if they so desired, and was not intended to oust the district court's declaratory judgment and mandamus jurisdiction. *See Melvin v. Laird*, 365 F. Supp. at 516-19.

Other courts adhere to the view that the nonmonetary jurisdiction of the Claims Court is exclusive, and that the district court may not exercise

(footnote continues)

Megapulse, Inc. v. Lewis, 672 F.2d 959, 971 (D.C. Cir. 1982); *Rowe v. United States*, 633 F.2d 799, 801-02 (9th Cir. 1980), *cert. denied*, 451 U.S. 938 (1981); *cf. Sellers v. Brown*, 633 F.2d 106, 108 (8th Cir. 1980), *cert. denied*, 451 U.S. 938 (1981). The fact that a suit for nonmonetary relief in the district court may also provide a basis for a grant of money damages against the United States is not a sufficient reason to foreclose district court jurisdiction. *See Duke Power Co. v. Carolina Environmental Study Group, Inc.*, 438 U.S. 59, 71 n.15 (1978); *Laguna Hermosa Corp. v. B.E. Martin*, 643 F.2d 1376, 1379 (9th Cir. 1981); *Melvin v. Laird*, 365 F. Supp. at 520; *see also Beller v. Middendorf*, 632 F.2d 788, 799 (9th Cir. 1980), *cert. denied*, 452 U.S. 905 (1981). However, the power of the district court in these types of cases is limited; sovereign immunity of the United States is waived in the district court under 5 U.S.C. § 702 (1982) only for claims against a federal agency or its officers seeking relief "other than money damages." *See United States v. Mitchell*, 51 U.S.L.W. 4999, 5005 & n.32 (June 27, 1983); *Jaffee v. United States*, 592 F.2d 712, 718-19 (3d Cir. 1979). *See generally* K. Davis, *Administrative Law Treatise* § 27.00-.10 (Supp. 1980 & 1982). This jurisdictional limitation results in a bifurcation of claims between the district court and the Claims Court, because the district court is unable to grant monetary relief on claims over \$10,000. *See Giordano v. Roudebush*, 617 F.2d at 514-15; *Laguna Hermosa Corp. v. B.E. Martin*, 643 F.2d at 1379 (9th Cir. 1981); *Rowe v. United States*, 633 F.2d at 801-02; *Beller v. Middendorf*, 632 F.2d at 799; *Melvin v. Laird*, 365 F. Supp. at 518-19. *But cf. Woodland Nursing Home Corp. v. Califano*, 487 F. Supp. 9, 11-13 (S.D.N.Y. 1979) (district court with jurisdiction over nonmonetary claim can exercise pendent jurisdiction over monetary claim to provide a "common sense solution" for complete relief in one court). Such bifurcation is unavoidable when the Claims Court lacks the power to grant the type of

(footnote continued)

concurrent equitable jurisdiction regardless of whether the equitable relief sought may be categorized as "primary." *See, e.g., Keller v. Merit Systems Protection Board*, 679 F.2d at 222-23; *Denton v. Schlesinger*, 605 F.2d 484, 486-88 (9th Cir. 1979); *Shaw v. Pierce*, 534 F. Supp. 735, 738-39 (E.D. Cal. 1982).

declaratory or injunctive relief sought. See *Rowe v. United States*, 633 F.2d at 801-02; *Shaw v. Pierce*, 534 F. Supp. at 738. *Contra Woodland Nursing Home Corp. v. Califano*, 487 F. Supp. at 11-13.

Under the facts involved in this dispute, the disallowance is rooted in the federal agency's guidelines interpreting the meaning of the statutory phrase "institution for mental diseases." The guidelines have an effect upon current and future federal benefits to the State in addition to past federal financial participation. The State estimates that potentially over \$10 million in federal funds to the State of Minnesota are at stake here, representing not only past claims collected but other claims foregone when Minnesota stopped submitting further claims after the disallowances in 1978 to avoid risking additional losses. The potential current and future claims foregone dwarf the amount of the disallowance the State seeks to have overturned. Although the Claims Court possesses the jurisdiction necessary to make a legal ruling upon which to base the award of a money judgment, see *Pauley Petroleum Inc. v. United States*, 591 F.2d 1308, 1315 (Ct. Cl.), cert. denied, 444 U.S. 898 (1979), the declaratory relief sought here has conspicuous impact beyond establishing a right to the disallowed funds.¹² The prospective, independent significance of the declaratory relief requested makes it, not the compensatory

¹² The other relief requested by the State of Minnesota for an order to restore the disallowed funds and for a permanent injunction barring future recovery of that money only relates to the monetary compensation desired by the State for the disallowance. Claims essentially seeking monetary relief over \$10,000 fall within the Claims Court's exclusive jurisdiction which may not be evaded by framing a claim for injunctive relief or by requesting the exercise of mandamus jurisdiction. See *Portsmouth Redevelopment and Housing Authority v. Pierce*, 706 F.2d 471, 474 (4th Cir. 1983); *Polos v. United States*, 556 F.2d 903, 905 n.5 (8th Cir. 1977); *Wingate v. Harris*, 501 F. Supp. 58, 61-62 (S.D.N.Y. 1980) (Medicaid disallowance); *State Department of Public Welfare v. Califano*, 388 F. Supp. 1304, 1308 (W.D. Tex. 1975) (state Medicaid claim), modified in part on other grounds, 556 F.2d 326, 332 (5th Cir. 1977), cert. denied, 439 U.S. 818 (1978). But see *Minnesota v. Weinberger*, 359 F. Supp. 789, 791-92 (D. Minn. 1973) (mandamus power

(footnote continues)

money payments, the primary relief sought by the State of Minnesota.¹³ Therefore the district court had jurisdiction over the nonmonetary claims under 28 U.S.C. § 1331 (1976 & Supp. V 1981) and 28 U.S.C. § 2201 (1976 & Supp. V 1981).¹⁴

(footnote continued)

authorized order of payment by federal agency to state for claim under Social Security Act).

Furthermore, an injunction is inappropriate when the injury can be redressed fully by an award of damages. E.g., *Wingate v. Harris*, 501 F. Supp. at 62. Likewise, the exercise of mandamus power is not properly invoked when another adequate remedy is available. *Id.*; *State Department of Public Welfare v. Califano*, 388 F. Supp. at 1308.

This case is unlike the situation in *State Highway Commission v. Volpe*, 479 F.2d 1099, 1104, 1123 (8th Cir. 1973), where injunctive relief to cease unauthorized action would automatically make benefits available. In contrast, affirmative action barred by the doctrine of sovereign immunity would be required to produce essentially compensatory payments to the State of Minnesota. See *Johnson v. Mathews*, 539 F.2d 1111, 1124 n.21 (8th Cir. 1976).

¹³ In contrast, a dispute over a Medicaid disallowance in *Wingate v. Harris*, 501 F. Supp. 58, 60-62 (S.D.N.Y. 1980), principally involved monetary relief and thus fell within the exclusive jurisdiction of the Claims Court. The district court categorized the requested declaratory and injunctive relief as ancillary under the facts involved, reasoning:

While it is true that plaintiffs seek several "declarations" regarding the invalidity of various HEW regulations and the illegality of the Secretary's actions thereunder, this relief is merely incidental to the primary remedy requested: an order directing payment of the monies withheld by the Secretary. The declaratory relief sought simply establishes plaintiffs' legal entitlement to this principal remedy, and does not expand it in any meaningful way. . . . Nowhere . . . is it alleged that this regulation is in current use to deprive plaintiffs of any benefit. Rather, the gist of their claim is that its application in the past with respect to the three nursing homes discussed above operated to deprive them of federal funds to which the Act entitled them. This claimed injury can be redressed fully by an award of damages. . . .

Id. at 62 (emphasis added).

¹⁴ It is apparent that cooperation from HHS would obviate the need for the state to bring a separate suit in the Claims Court to obtain monetary relief for the funds disallowed here. Cf. *Connecticut v. Schweiker*, 557 F. Supp. at 1091 ("This court trusts that HHS . . . will promptly restore any setoff already taken. An injunction is therefore unnecessary.").

III. The Merits.

In deciding that the three facilities in question were "institutions for mental diseases" (IMD) under agency interpretive guidelines, the HHS' Departmental Grant Appeals Board reached conclusions of both fact and law. The agency's formal findings of fact will be upheld if supported by substantial evidence in the record considered as a whole. See *Citizens To Preserve Overton Park, Inc. v. Volpe*, 401 U.S. 402, 414-15 (1971); *Volkswagenwerk Aktiengesellschaft v. Federal Maritime Commission*, 390 U.S. 261, 272 (1968); *Consolo v. Federal Maritime Commission*, 383 U.S. 607, 619-21 & n.19 (1966); 5 U.S.C. § 706(2)(E) (1982); see generally K. Davis, *supra*, §§ 29.01-11 (1958 & Supp. 1980 & 1982).

In contrast, the agency's guidelines interpreting a statutory term and a regulation ultimately involve questions of law which are to be resolved by the court. See *Batterton v. Francis*, 432 U.S. 416, 424-26 & n.9 (1977); *Social Security Board v. Nierotko*, 327 U.S. 358, 368-69 (1946); *White Industries, Inc. v. Federal Aviation Administration*, 692 F.2d 532, 534 (8th Cir. 1982); 5 U.S.C. § 706 (1982). "Ordinarily, administrative interpretations of statutory terms are given important but not controlling significance."¹⁵ *Batterton v. Francis*, 432 U.S. at 424; *Skidmore v. Swift & Co.*, 323 U.S. 134, 140 (1944). *Research Medical Center v. Schweiker*, 684 F.2d 599, 602 (8th Cir. 1982); see generally K. Davis, *supra*, § 30.13.

¹⁵ The unpublished interpretive guidelines in question here do not reflect an exercise of expressly delegated congressional authority to prescribe substantive standards for determining the meaning of the statutory phrase "institution for mental diseases." Compare *General Electric Co. v. Gilbert*, 429 U.S. 125, 141-45 (1976); *Morton v. Ruiz*, 415 U.S. 199, 236-37 (1974); *Social Security Board v. Nierotko*, 327 U.S. at 369 ("Except as such interpretive power may be included in the agencies' administrative functions," Congress did not delegate to the Social Security Board power to define the statutory term.) with *Herweg v. Ray*, 455 U.S. 265, 274 (1982) (When a term in the statute is followed by a phrase such as "as determined in accordance with standards prescribed by the Secretary," definitional regulations are to be given legislative effect.); *Schweiker v. Gray Panthers*, 453 U.S. 34, 37, 43-44 (1981) (same); *Batterton v. Francis*, 432 U.S. at 424-26 & n.9 (1977) (same).

As in all cases focusing on statutory construction, we must initially look to the language chosen by Congress. *American Tobacco Co. v. Patterson*, 456 U.S. 63, 68 (1982); *Bread Political Action Committee v. Federal Election Committee*, 455 U.S. 577, 580 (1982). The ordinary meaning of the words used are [sic] presumed to express congressional purpose; thus, absent clearly expressed legislative intention to the contrary, the language is regarded as conclusive. *American Tobacco Co. v. Patterson*, 455 U.S. at 68.

The Medicaid statute defines federal "medical assistance" for needy individuals to include, among other items, "intermediate care facility services (*other than such services in an institution for tuberculosis or mental diseases*) for individuals who are determined . . . to be in need of such care." 42 U.S.C. § 1396d(a)(15) (1976) (emphasis added). The identical exclusion for services in an IMD is repeated in sections granting medical assistance for "inpatient hospital services" and "skilled nursing facility [SNF] services." *Id.* § 1396d(a)(1), (4A). A correlating section, however, allows payments for "inpatient hospital services, skilled nursing facility services, and intermediate care facility services for individuals 65 years of age or over, in an institution for tuberculosis or *mental diseases*." *Id.* § 1396d(a)(14) (emphasis added). Additionally, the statute provides for funds for "inpatient psychiatric hospital services for individuals under age 21." 42 U.S.C. § 1396d(a)(16) (1976 & Supp. 1981). The statutory definition of "medical assistance" clarifies the prohibition against payments for individuals between age 21 and 65 in an IMD: "[E]xcept as otherwise provided in paragraph (16) [inpatient psychiatric services for individuals under age 21], such term ["medical assistance"] does not include . . . any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient *in an institution for tuberculosis or mental diseases*." *Id.* § 1396d(a)(18)(B) (emphasis added).

Of significance here is the statutory definition of an ICF:

[T]he term "intermediate care facility" means an institution which (1) is licensed under State law to

provide, on a regular basis, *health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who because of their mental or physical condition require care and services (above the level of room and board)* which can be made available to them only through institutional facilities The term "intermediate care facility" also includes any skilled nursing facility or hospital which meets the requirements of the [preceding] sentence With respect to services furnished to individuals under age 65, the term "intermediate care facility" shall not include, except as provided in subsection (d) of this section,¹⁶ any *public institution or distinct part thereof for mental diseases or mental defects*.

Id. § 1396d(c) (emphasis added).

Conspicuously omitted from section 1396d is any statutory characterization of an "institution for mental diseases." The Secretary, however, has promulgated a regulation defining an IMD:

"Institution for mental diseases" means an institution that is *primarily engaged in providing diagnosis, treatment or care of persons with mental diseases*, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its *overall character* as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.

42 C.F.R. § 435.1009e (1982) (emphasis added). *See also id.* § 440.140(a)(2).

¹⁶ The reference to "subsection (d)" allows medical assistance for ICF services in a "public institution (or distinct part thereof) for the mentally retarded . . . receiving active treatment." 42 U.S.C. § 1396d(d) (1976).

The consistency of this regulation with the statute is not contested here.¹⁷ What is attacked is the agency's finding that the three facilities in question are IMDs based on HHS' interpretation of this regulation. Certain unpublished agency guidelines were employed to determine the overall character of these facilities as IMDs. The operating guidelines were developed in response to perceived problems of deinstitutionalization whereby some patients between 21 and 65 years old in state mental hospitals, for which federal Medicaid payments were not obtainable, were relocated by the states in community-based residential facilities, such as ICFs, for which federal funds were available. HHS circulated intra-office instructional bulletins to assist federal field office personnel in their determinations as to the "overall character" of a facility. The following criteria identifying IMDs were used:

1. A facility is licensed as a mental institution;
2. It advertises as a mental institution;
3. More than 50 percent of the patients have a disability in mental functioning [as defined in the *International Classification of Diseases*];
4. It concentrates on managing patients with behavior or functional disorders and is used largely by mental hospitals for alternative care;
5. It is under the jurisdiction of the mental health authority;
6. It is frequently or predominantly used for individuals who are either discharged from mental hospitals or would otherwise be admitted to them;
7. The facility is in proximity to a State Mental Institution (for example, within a 25-mile radius);
8. The age distribution is uncharacteristic of nursing home patients; and

¹⁷ *See* 42 U.S.C. § 1302 (1976 & Supp. V 1981) (providing that the Secretary "shall make and publish such rules and regulations, not inconsistent with this Chapter, as may be necessary to the efficient administration of the functions with which . . . [she] is charged under this Chapter").

9. The basis of Medicaid eligibility for patients under 65 is a mental disability.

Letter from Tera S. Younger, HCFA Long Term Care Policy Group, to B. F. Simmons (Nov. 3, 1980) (with Discussion Paper: *Redefinition on Institution for Mental Diseases* attached). See HHS Field Staff Information and Instruction Series (FSIIS) FY-76-156 (Sept. 14, 1976); FY-76-97 (May 3, 1976); FY-76-44 (Nov. 7, 1975).

The State of Minnesota asserts that these criteria interpreting the IMD regulation conflicts [sic] with the Medicaid provisions of the Social Security Act and with agency regulations. The State contends that if a definition consistent with the statute had been applied, the three facilities would not have been classified as IMDs. It urges that Congress intended the phrase "institution for mental diseases" to apply only to state mental hospitals, or alternatively, that the term applies only to institutions whose primary purpose is to provide specialized care or services for mental illness. Thus, the State contends, inquiry into whether a facility is an IMD must focus on the nature of services that the facility renders, not on the diagnosis or type of illness manifested by the patient. It stresses, for example, that the use of the "51% rule" based on the number of patients in a home with diagnoses of mental diseases is a particularly inappropriate and arbitrary factor under the statute.

The agency defends its position by pointing to the statutory section 1396d(a) which lists hospital services separately from SNF and ICF services, and then excludes from payment all three types of services in an IMD. Thus, it says, all IMDs are not traditional mental hospitals. Under its view, the term IMD must be able to include SNFs and ICFs or else the word "hospital" would be superfluous because of being incorporated into the term IMD. HHS argues that the Board's decision upholding the disallowance was rationally based, that the guideline criteria were rationally related to identification of an IMD, and that no one criterion was determinative. It finds the State's argument against the "51% rule" unfounded here when at least 86% of the patients at each of the three facilities had diagnoses of a mental disease. It maintains that adoption of

Minnesota's position focusing on type of care given would result in rewarding facilities which do not provide the services required by patients' diagnoses.

We hold that the Board's interpretation of its regulation defining an IMD, and its extensive reliance on diagnoses-based criteria for the purpose of revealing the overall character of an IMD, were inconsistent with the provisions and purposes of the Social Security Act. *Accord Connecticut v. Schweiker*, 557 F. Supp. 1077, 1091 (D. Conn. 1983). We find that the characterization of an IMD must fundamentally center on the type of care or nature of services required, not on the mere presence in a facility of patients who have, or at one time did have, diagnoses of a mental disease. Thus, because insufficient fact finding was performed on the proper basis, we hold that the Board's decision upholding the disallowance was not supported by substantial evidence on the record as a whole.

Our conclusion is rooted in the language of section 1396d defining "medical assistance," and is supported by legislative history as well as other statutory provisions of the Social Security Act. The skeletal framework of allowable "medical assistance" payments in section 1396d(a) is built around various types and levels of care; the section specifies payments for "inpatient hospital services," "skilled nursing facility services," "intermediate care facility services," "inpatient psychiatric hospital services," and so on. 42 U.S.C. § 1396d(a)(1), (4)(A), (15), (16) (1976). The statute specifies payments for "intermediate care facility services . . . for individuals who are determined, in accordance with section 1396a(31)(A) of this title, to be *in need of such care*."¹⁸ 42 U.S.C. § 1396d(a)(15) (1976) (emphasis added).

¹⁸ Likewise, the definitions of "inpatient hospital services for individuals under age 21," "skilled nursing facility services," and ICF care for the mentally retarded all center on the nature of care required by patients. The term "inpatient psychiatric hospital services for individuals under age 21" includes only "active treatment . . . necessary on an inpatient basis and can reasonably be expected to improve the condition, by reason of which such services are necessary, to the extent that eventually such services will no longer be necessary." 42 U.S.C. § 1396d(h)(1)(B) (1976) (emphasis added).

(footnote continues)

Section 1396d(c) defining an "intermediate care facility"¹⁹ supplies manifest clarification not only of what an ICF is, but more importantly for our purposes, how an IMD is and is not to be exclusively characterized. The ICF definition expressly authorizes care of patients in an ICF with diagnoses of either "mental or physical condition[s]" as long as the illnesses involved "require" a lesser "degree of care and treatment" than a hospital or SNF provides.²⁰ Cf. *Pinneke v. Preisser*, 623 F.2d 546, 550 (8th Cir. 1980) (statutory limitations for IMDs "do not apply to mental health problems in general").

The legislative history of the IMD exclusion and ICF coverage reinforces the statutory language that Medicaid benefits cannot be denied solely on the ground that an institution primarily serves mental patients and that the paramount criterion for distinguishing an IMD from an ICF must be the degree of care and treatment required by patients. The limitation in the Social Security Act for patients in an "institution for mental diseases" was first enacted in 1950 based on the reason that "long-term care in such hospitals had traditionally been accepted as a responsibility of the States." *Schweiker v. Wilson*, 450 U.S. 221, 237 n.19 (1981); see *id.* at 225 n.5. A House report in 1963 stressed the deficiencies of the "State

(footnote continued)

The term skilled nursing facilities means "services which are or were required to be given an individual who needs or needed on a daily basis skilled nursing care...or other skilled rehabilitation services." *Id.* § 1396d(f).

As to care for the mentally retarded, section 1396d(d) states:

The term "intermediate care facility services" may include services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions if—

(1) the primary purpose of such institution (or distinct part thereof) is to provide health or rehabilitative services for mentally retarded individuals and...

(2) the mentally retarded individual...is receiving active treatment under such a program....

Id. (emphasis added).

¹⁹ See *supra* p. 15-16.

²⁰ Many persons within an ICF may be deaf or blind or have other physical ailments in conjunction with associated mental problems.

mental institutions": "Only a small percentage of the institutions can be said to be therapeutic and not merely custodial. In 1959, there... [was] less than 1 psychiatrist for 500 patients." H.R. Rep. No. 694, 88th Cong., 1st Sess. 11, reprinted in 1963 U.S. Code Cong. & Ad. News 1054, 1064.

In contrast, the Medicaid program, which was enacted as Title XIX of the Social Security Act in 1965, was "designed to alleviate the cost of health care which is active and remedial rather than custodial in nature." *Legion v. Richardson*, 354 F.Supp. 456, 459 (S.D.N.Y.), *aff'd sub nom. Legion v. Weinberger*, 414 U.S. 1058 (1973); accord *Woe v. Matthews*, 408 F. Supp. 419, 425 n.16 (E.D.N.Y. 1976), *aff'd mem. sub nom. Woe v. Weinberger*, 562 F.2d 40 (2d Cir. 1977), *cert. denied* 434 U.S. 1048 (1977). The purpose of Title XIX is expressly decreed "to furnish... medical assistance..., rehabilitation and other services to help... individuals attain or retain capability for independence or self-care." 42 U.S.C. § 1396 (1976).

Congress recognized the "great strides in the field of mental disease" which allowed the development of mental health programs "to cure the patients and release them from the institutions, instead of requiring them to spend the rest of their lives in them." 111 Cong. Rec. 21, 348-49 (1964) (statements of Sen. Long). Congress thus authorized exceptions to the IMD exclusion in 1965 for the mentally ill in general medical facilities and for individuals age 65 and over in IMDs.²¹ However, the exceptions were granted on the condition that the states arrange with IMDs to develop alternative methods of care for all mental patients, "particularly for the aged who are mentally ill." S. Rep. No. 404, 89th Cong., 1st Sess. 146, reprinted in 1965 U.S. Code Cong. & Ad. News 1943, 2085; see *Connecticut v. Schweiker*, 557 F. Supp. at 1083 n.13,

²¹ In discussing the bill removing the exclusion for those over age 65, Senator Carlson observed: "Whether an individual of advanced years is merely senile or has a mental disease is a fine line and it may be appropriate for him at one time to be in a mental institution and at another to be in a nursing home, his own home, or in some other arrangement." 111 Cong. Rec. 21, 349 (1964). Appropriate patient placement was thus a motivating factor in removing the IMD exclusion for those age 65 and over. Accord *Connecticut v. Schweiker*, 557 F. Supp. at 1083 n.13.

1084 n.15. This legislation, requiring "plans for the use of other methods of care, such as nursing homes, short-term care in general hospitals, foster family care, and others," besides the standard "[i]nstitutional treatment and care in the individual's own home," was intended to "give further encouragement to the trend in the States for discharging from mental hospitals to the community the aged who are considered able to care for themselves, under some form of protective arrangements." S. Rep. No. 404, 89th Cong., 1st Sess. 146, *reprinted in* 1965 U.S. Code Cong. & Ad. News 1943, 2085. See 42 U.S.C. § 1396a(a)(20), (21) (1976 & Supp. V 1981).

ICF coverage was added to the Medicaid provisions in 1971 and was explicitly intended for persons who "in the absence of intermediate care would require placement in a skilled nursing home or mental hospital." Report of Senate Finance committee, printed in Statement of Sen. Long, 117 Cong. Rec. 44721 (1971) (emphasis added). The development of ICFs was a direct response to the congressional aim of providing the most appropriate placement required by a patient's physical or mental health needs. The committee report on ICFs stressed the concern that "each patient for whom Federal funds is provided is in the right place at the right time receiving the right care Each skilled nursing home, each mental hospital patient, and each intermediate care patient must be individually reviewed by an independent team to assure proper placement." *Id.* The report recited the congressional desire to "provide a less costly institutional alternative" than "skilled nursing home care" for patients who needed care "less extensive than skilled nursing home care." *Id.* ²²

²² In 1972, Congress "further broadened Medicaid benefits for the mentally ill to include most children in mental institutions." *Schweiker v. Wilson*, 450 U.S. at 226 n.5. See 42 U.S.C. § 1396d(a)(16) (1976 & Supp. V 1981) ("inpatient psychiatric hospital services for individuals under age 21"). Congress simultaneously defeated a Senate proposal for demonstration projects to evaluate the "potential social and economic benefits of extending medicaid inpatient mental hospital coverage to mentally ill persons between the ages of 21 and 65." S. Rep. No. 1230, 92d Cong., 2d Sess. 280-81 (1972); see H.R. Conf. Rep. No. 1605, 92d Cong., 2d Sess. 65, *reprinted in* 1972 U.S. Code Cong. & Ad. News 4989, 5398.

The impropriety of focusing upon a diagnosis of mental illness is also supported by congressional directives prohibiting discrimination on the basis of diagnosis, 42 U.S.C. § 1396a(a)(10) (1983), or handicap, 29 U.S.C. § 794 (1976 & Supp. V 1981).²³ An HHS Medicaid regulation in accord declares that a "Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service . . . to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition." 42 C.F.R. § 440.230(c) (1982).²⁴

In a recent case involving eligibility for Supplemental Security Income benefits which were tied into Medicaid eligibility, the Supreme Court determined that the exclusion of benefits to any "inmate of a public institution" could not be classified directly on the basis of a diagnosis relating to mental health. *Schweiker v. Wilson*, 450 U.S. at 224-25, 231. Congress, the Court said, distinguished not between the mentally ill and a group composed of nonmentally ill, but between residents in public institutions receiving Medicaid funds for their care and residents in such institutions not receiving Medicaid funds. *Id.* at 232-33.

Unlike the situation in *Wilson*, however, here the stipulated criteria directly classify by mental diagnoses in order to determine whether an institution should receive Medicaid funds.

By its very nomenclature, a threshold requirement for an "institution for mental diseases" must be the presence of patients with a mental disease. However, most of the interpretive criteria in dispute here directly pertain to the mere

²³ HHS regulations under section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 (1976) define "handicap" to include any mental disorder. See 45 C.F.R. § 84.3(j) (1982).

²⁴ The State's brief quotes statements of HHS in the early 1970's that "[f]ederal sharing with the States is available for the cost of most types of care for the mentally ill because Title XIX prohibits elimination of patients from the program on the basis of diagnosis." Brief for petitioner at 30, quoting Social Security Administration, Office of Research and Statistics, U.S. Dept. of H.E.W., Research Report No. 37, Financing Mental Health Care Under Medicare and Medicaid 39 (1971).

existence of present or past mental disabilities of the patients in a facility. When HHS interprets the major distinctive features of an IMD to turn on this factor, it negates a portion of the statute by encroaching upon the intended role Congress determined intermediate care facilities were designed to serve.²⁵ An agency's interpretation of its own regulations cannot emasculate the plain meaning of the governing statute. See *United States v. Menasche*, 348 U.S. 528, 538-39 (1955).

We do not find it necessary to explore fully the degree of care and treatment that only placement in an IMD can provide. It certainly includes treatment similar to "inpatient psychiatric hospital services" as defined for individuals under age 21 in section 1396d(h)(1)(B). See *supra* note 18; 42 U.S.C. § 1396d(a)(16) (1976 & Supp. V 1981). Legislative history is clear that in allowing such coverage for children, Congress intended to make an exception to the under-age-65 IMD exclusion. S. Rep. No. 1230, 92d Cong., 2d Sess. 280-81 (1972); see *Kantrowitz v. Weinberger*, 388 F. Supp. 1127, 1129-30 (D.D.C. 1974), *aff'd*, 174 U.S. App. D.C. 182, 530 F.2d 1034, *cert. denied*, 429 U.S. 819 (1976); cf. 42 C.F.R. § 440.140(a)(ii) (1982) (IMDs must meet general requirements of a psychiatric hospital to be included in Medicaid

²⁵ The agency itself has expressed doubts as to the validity and effectiveness of some of the guidelines. A Discussion Paper of "Redefinition On Institution For Mental Diseases" observed:

These guidelines lack regulatory force and contain some criteria that are of questionable applicability in determining whether a facility is an IMD, e.g., whether the facility is located within a 25-mile radius of a State mental hospital. . . . [W]e believe that objective criteria for identifying an IMD need to be incorporated into the regulations. We exercised [sic] the possibility of incorporating criteria related to the percentage of mentally ill individuals in skilled nursing facilities and intermediate care facilities. We have reservations about this, however, because the criteria (particularly the numerical criterion) do not necessarily indicate the nature of the services being furnished by the facility and enforcement may provide an undesirable incentive for substitution of nonpsychiatric diagnoses and transfer of patients to avoid reaching the guideline percentile.

Letter from Tera S. Younger, HCFA Long Term Care Policy Group, to B. F. Simmons (Nov. 3, 1980) (Discussion Paper attached) (emphasis added).

coverage for those over age 64). IMD treatment may thus include a higher degree of care and treatment than is provided by facilities which only offer SNF or ICF services. However, based on legislative history, it also may include custodial "room and board" care which is not aimed at simultaneously providing active or therapeutic treatment leading to cure. See *supra* at 21-22; *Connecticut v. Schweiker*, 557 F. Supp. at 1084-85; *Woe v. Matthews*, 408 F. Supp. at 422, 426-29 & n.23.²⁶

We conclude that the agency acted contrary to statutory provisions and congressional intent when, to identify the overall character of these three facilities as IMDs, it employed criteria chiefly focusing on the mere presence in each facility of patients with diagnoses of a mental disability. We hold that the cardinal gauge by which to distinguish IMDs and ICFs must be the degree of care and treatment required by the mental or physical conditions of patients residing at any given facility.²⁷ We thus hold that the Board's decision upholding the disallowance to the State was unsupported by substantial evidence on the record as a whole. We reverse the decision and remand

²⁶ The district court found that "by 'institution for mental diseases' the Congress intended to refer to those institutions which provided primarily long-term care for the mentally ill by administering psychiatric treatment for its residents on the premises." *Minnesota v. Schweiker*, No. 4-82-155, slip op. at 15 (D. Minn. Aug. 25, 1982).

The district court in *Connecticut v. Schweiker*, 557 F. Supp. at 1081 n.8, expressly disagreed with this characterization, finding that long-term care and psychiatric care are not necessary for a facility to be an IMD, but that "total care" is. That court defined "total care" to mean "the very high level of care given, for example, to a hospital inpatient or a nursing home resident. The patient is totally dependent on the institution and is submerged in it." *Id.* at 1081 n.9.

Cf. *Schweiker v. Wilson*, 450 U.S. at 233 n.17 ("the average inpatient stay in public mental hospitals is short"; the "rapidity with which inpatients are released from public institutions has increased since the 1950's").

²⁷ The degree of care and treatment required by a patient's mental or physical condition should be equivalent to the degree of care and treatment furnished to the patient by a facility. Emphasis on the degree of care and treatment required by patients in order to determine whether the overall character of a facility is that of an IMD should eliminate HHS' concern that a facility would be rewarded if the nature of its services did not sufficiently

(footnote continues)

to HHS. We do not reach the procedural issues raised by the State pertaining to the requirements of the Administrative Procedure Act, 5 U.S.C. § 552 *et seq.* (1982), that the guidelines employed must be published.

The district court is thus affirmed in part in its grant of summary judgment to the State and denial of summary judgment to HHS. The district court's order is vacated for lack of jurisdiction as to that portion of the order which requires that the Secretary shall return to the State the federal funds withheld pursuant to the disallowance.

The petition filed by the State of Minnesota (No.) for direct review of the agency's decision is dismissed for lack of jurisdiction.

A true copy.

ATTEST:

CLERK, U.S. COURT OF APPEALS,
EIGHTH CIRCUIT.

(footnote continued)

provide the level of care required by a patient's mental diagnosis. The statute requires that state plans for medical assistance provide for independent professional review of the need for intermediate care prior to admission in an ICF, and periodic review of the type and adequacy of care being provided, the necessity and desirability of continued ICF placement, and the feasibility of meeting a patients' [sic] need through alternative institutional or non-institutional services. 42 U.S.C. § 1396a(a)(31) (1976); 42 C.F.R. part 456 (1982); see *Colorado Department of Social Services v. Department of Health and Human Services*, 558 F. Supp. 337, 340-47, 348-55 (D. Colo. 1983). By disputing individual placement decisions, HHS can insure the equivalency of the degree of care and treatment rendered by a facility and the degree required by patients.

APPENDIX F
IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT
OF ILLINOIS
EASTERN DIVISION

No. 82 C 1349

STATE OF ILLINOIS, BY THE
ILLINOIS DEPARTMENT OF PUBLIC AID,

Plaintiff,

v.

UNITED STATES DEPARTMENT OF
HEALTH AND HUMAN SERVICES AND
MARGARET HECKLER, SECRETARY OF
HEALTH AND HUMAN SERVICES,

Defendants.

MEMORANDUM OPINION AND ORDER

SUSAN GETZENDANNER, *District Judge:*

This matter is before the court on defendant HHS's written objections to the report and recommendation dated September 27, 1983, submitted by Magistrate James T. Balog. (Attached as Appendix A.) The Magistrate recommended that the court grant plaintiff Illinois' motion for summary judgment and deny HHS's cross-motion for summary judgment. Upon its own de novo review of issues objected to, Fed.R.Civ.P. 72(b), the court accepts the Magistrate's recommendation. As indicated below, however, the court does not accept all of the Magistrate's reasoning. The following discussion assumes knowledge of the basic facts (and of the standard abbreviations), as set out in the Magistrate's report.

Interpreting the fundamental purpose of the statutory IMD exclusion is central to this dispute. The Magistrate correctly concluded that in excluding IMDs Congress intended to exclude certain types of institutions for people with mental diseases, in particular those providing traditional treatment and care of such persons. Congress did not intend to exclude all institutions providing care to people with mental diseases, and the Congressional plan seems to be to encourage the development of alternative care facilities for those with mental diseases. The definition of an IMD therefore must depend in large part on the type of care and treatment provided. Excessive reliance on the percentage of residents having a mental disease is inconsistent with Congressional intent and with the statutory scheme. The other courts that have reviewed the Board's disallowance decision all have reached this same conclusion concerning the IMD exclusion. *State of Minnesota v. Heckler*, 718 F.2d 853 (8th Cir. 1983), *aff'g in part and vacating in part State of Minnesota v. Schweiker*, No. 4-82-155 (D. Minn. Aug. 25, 1982); *State of Connecticut, Department of Income Maintenance v. Schweiker*, 557 F.Supp. 1077 (D. Conn. 1983).

In construing the statutory term IMD the Magistrate went beyond a determination that the definition of IMD must relate in large part to the type of treatment provided. The Magistrate concluded that the term IMD was intended to refer to institutions providing long-term care for the mentally ill by administering psychiatric treatment for residents on the premises. (Magistrate's report, p. 7.) This interpretation also was given by the district court in *Minnesota v. Schweiker*. In *Connecticut v. Schweiker* the court disagreed with this reading, and instead interpreted the term IMD as requiring "total care." 557 F.Supp. at 1081 & n.8. Illinois proposes another definition. Illinois would read the statutory term IMD as covering only state mental hospitals and their private equivalents. The court sees no reason to embrace any of these positions. The Magistrate did not have the benefit of the Eighth Circuit's decision in *Minnesota v. Heckler*, 718 F.2d 852, issued shortly after the Magistrate filed his report. In that case the Court concluded that "the paramount criterion for distinguishing an IMD from an ICF must be the degree of care

and treatment required by patients." *Id.* at 863. The Court did not, however, attempt to formulate a working definition of an IMD. This court believes the Eighth Circuit's approach to be correct.¹ The courts lack the expertise and resources necessary to set down precise definitions of the type attempted by the Minnesota and Connecticut district courts. To review the decision of the Grant Appeals Board, it is necessary only to recognize that the type of treatment provided must be accorded some significant weight in characterizing an institution as an IMD. The Board placed no weight at all on this consideration, and the court thus is required to set aside the Board's decision, no matter how, precisely, the question of treatment should be factored into the definition of an IMD.

Congress has not defined the term IMD, but HHS has:

"Institution for mental diseases" means an institution that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for the mentally retarded is not an institution for mental diseases.

42 C.F.R. § 435.1009(e) (1982). This regulatory definition suggests an emphasis on the counting of "persons with mental diseases," but the definition's reference to "overall character" arguably contemplates consideration of factors other than the composition of the resident population. The Board in fact understood "overall character" in this way. The Board stated:

As stated above, the Agency was reasonable in looking to patient population as a factor in determining the "overall character" of a facility.

¹ By embracing the approach taken by the Eighth Circuit, the court does not intend to hold that the categories of IMD and ICF are mutually exclusive, as the quoted passage may seem to suggest.

* * *

For the Agency to take some risk of misclassification [in counting residents with a mental disease] was reasonable, where the patient population was not the sole basis for determining "overall character."

* * *

This concern [with a hypothetical shift in population from just below to just above the 50% guideline] is irrelevant here, however, given the high percentages of mentally ill in most of the facilities during the disallowance periods and since other significant factors also evidenced "overall character" of the facilities as IMDs.

(Decision, pp. 33-34.) In this court, too, HHS purports to rely on a broad range of factors. HHS describes the composition of the resident population as merely a "logical, important factor in determining the nature of an institution." (HHS memo in support of summary judgment, p. 36.) HHS maintains that it never relied on any single criterion in characterizing facilities as IMDs. (HHS memo in support of summary judgment, p. 40.)

Despite these disavowals of patient-counting as the sole basis for characterizing a facility as an IMD, the HCFA's Guidelines and the Board's review in effect relied almost exclusively on the percentage of residents within a facility that had a mental disease. The HCFA report stated:

Eight criteria have been set forth as the basis for a determination that a facility is an institution for mental diseases. Field Staff Information and Instruction Series (FSIIS) 76-44 dated November 7, 1975, . . . specifies that an institution is characterized as "primarily" one for mental diseases if:

- 1) It is licensed as such;
- 2) It is advertised as such; or
- 3) If more than 50 per cent of the patients have a diagnosis of mental disease, as defined in the *International Classification of Diseases*, Eighth Revision

The following five additional criteria are outlined in FSIIS 76-97 dated May 3, 1976 . . . FSIIS 76-156 dated September 14, 1976 . . . and Health, Education and Welfare Region IX legal opinion dated October 28, 1977 . . . as further support for a determination that a facility is an institution for mental diseases:

[4] Used by mental hospitals for alternative care;

[5] Patients who were accepted directly from the community but had been in mental hospitals;

[6] Proximity to State mental institutions (25 mile radius);

[7] Age distribution uncharacteristic of nursing home patients;

[8] Basis of Medicaid eligibility for patients under age 65 due to mental disability.

FSIIS 76-156 also defines a mental patient as one "with mental disability necessitating nursing home care who has no significant physical problems," or a " . . . Patient with physical problems that would not independently necessitate nursing home care, but who has a mental disability that would preclude his proper handling of his physical problem outside a nursing home"

(HCFA report dated March 5, 1979, pp. 2-3.)²

Only three of these criteria do not relate to counting or estimating the number of patients with a mental disease. Of these three criteria, two were not met in the case of any ICF in question here, and the third criterion, met in every case, is of virtually no probative value. The court has found no indication in the record that any of the facilities was licensed as an IMD, as in Guideline 1). The HCFA report found that no facility was advertised as an IMD, as in Guideline 2). All nine facilities

² The parties have disputed whether these guidelines should have been published. The court finds it unnecessary to address this question.

met Guideline 6), but this Guideline is almost useless. According to HHS, this Guideline "was useful because, in the process of deinstitutionalization of mental patients, many States established smaller institutions such as SNFs on the grounds or in the immediate vicinity of State mental hospitals." (HHS memo in support of summary judgment, p. 32.) A 25-mile proximity test, at least as applied in an urban area like Chicago, does nothing to determine whether a facility is merely ancillary to an IMD. There are IMDs in Chicago, and almost all ICFs in or near Chicago are within 25 miles of these IMDs. Five of the nine ICFs in question here are within the city limits of Chicago, and two more are in Evanston, which borders on Chicago. It is not clear whether the 25-mile test has any probative value as applied to the Chateau Waukegan, in Waukegan, or the Kankakee Terrace, in Bourbonnais.

The five remaining criteria all are ways of determining the number or percentage of residents with a mental disease. Guideline 3) explicitly involves the counting of residents.³ Guideline 7) obviously is another way of determining how many patients have a mental disease. The assumption apparently is that younger residents are likely to be in a facility because they have a mental disease. To the extent this assumption is not accurate, then the probative value of the test is weakened, because the test also would be counting younger residents with only physical disabilities. Guideline 8) clearly is a way of identifying residents with a mental disease.

Guidelines 4) and 5) do not necessarily relate only to the counting of patients. It seems that these Guidelines conceivably could be applied in a way that would help determine the type of treatment provided by a facility. If many residents came to a facility directly or indirectly from an IMD, the facility possibly might be providing IMD-type treatment. The Board found that Illinois was not "dumping" patients from mental hospitals into ICFs, as a state conceivably could do in order to collect FFP.

³ The accuracy of HCFA's counting of patients has been disputed hotly, both before the Board and in this court. The court finds it unnecessary to address this dispute.

Nonetheless, the Board found that the number of direct transfers into these facilities supported the conclusion that they were IMDs. The court has studied the HCFA report and page 42 of the Board's decision, discussing residents transferred from mental hospitals, and the court concludes that Guidelines 4) and 5), in their actual application, amounted to little more than another way of counting or estimating how many residents had a mental disease.

In addition to using these Guidelines, the HCFA also attempted to get a sense of how each institution viewed itself and how it was viewed by state authorities and others.⁴ The HCFA thus collected several statements to the effect that these ICFs served primarily mental health patients, which again merely reflects the composition of the resident population. The HCFA report does quote a few statements regarding the type of care given in some ICFs, particularly the Traemour Home. Where the HCFA does refer to the type of care given, the care generally seems oriented toward helping patients learn to function in everyday life. In the Traemour Home, residents take public transportation to shopping areas, attend workshops in the community, learn about current events and communication skills, and have a glamour clinic and a weight watching program; these residents are allowed to leave any time they wish, including overnight absences. The HCFA report does not discuss the nature or purpose of such treatment, and the court's impression is that the HCFA describes the treatment only for the purpose of confirming that most residents indeed have a mental disease. The court lacks HHS's administrative expertise in evaluating care and treatment, but it appears to the court that

⁴ The court notes that the HCFA report includes this passage:

A newspaper article published on October 24, 1978, in the Waukegan News Sun related the following on the character of Chateau Waukegan: "It has become a halfway house for discharged mental patients. It is a place for mentally unbalanced people. Downtown Waukegan was not meant to be a rehabilitation center for mental patients." (HCFA audit report dated March 5, 1979, p. 11.) The HCFA's apparent reliance on this material does not encourage deference to its determination. The Board did not comment specifically on this passage, noting only that the HCFA had examined newspaper articles. (Decision, p. 40.)

some of the treatment at the Traemour Home, for instance, referring residents to community agencies for "work preparation," is the type that would not predominate at an IMD, as Congress intended that term to be applied.

The Board did not discuss each guideline separately, but it found that the HCFA reasonably could have relied on the guidelines as a group. (Decision, p. 34.) The Board also discussed some other factors respecting the Illinois facilities. There was no discussion of the type of treatment given in the facilities, except that the Board observed that "while the [Grasmere Residential] Home did not provide 'mental treatment,' it did consider itself as providing some form of treatment to patients where therapeutically indicated." (Decision, p. 41.) The Board also discussed the role of the Illinois Department of Mental Health and Developmental Disabilities, noting that the Department had follow-up responsibilities for persons transferred from hospitals into ICFs. While some probative argument possibly could be based on the Department's role, the Board discounted its importance; however, the Board stated: "we nonetheless consider it some support for the general finding that high percentages of the patients were mentally ill." (Decision, p. 42.) Concluding its discussion of the Illinois facilities, the Board Stated:

Thus, while we find Illinois' evidence sufficient to establish certain facts, those facts are not directly relevant to the issues before us and do not overcome the Agency's finding that high percentages of the patients in the facilities had mental disorders and that the State in some way recognized that the facilities were primarily serving the mentally ill. Thus, we conclude that the facilities met the regulatory definition and were IMDs.

(Decision, p. 42.) It is beyond dispute that the Board relied almost exclusively on the percentage of residents in each facility having a mental disease, giving little or no consideration to the kind of treatment provided. In fact, HHS argues in this court that the provision of any kind of treatment to patients with a mental disease should contribute to a finding that a facility is an

IMD. (HHS memo in support of summary judgment, p. 39.) While the use of several guidelines and the phrase "overall character" may give a different appearance, the Board's decision gave no significant weight to any factor other than the composition of the resident population.

HHS argues that its interpretation of the statutory exclusion is entitled to deference, as the interpretation of the agency charged with implementing the statute. The court in the Connecticut case discussed this question at length and concluded that such deference would not be appropriate. 557 F.Supp. at 1089-91. The Eighth Circuit, without extensive discussion, indicated that HHS's interpretation could not control. 715 F.2d at 865. This court too deems it inappropriate to defer to HHS's position. At issue here is the fundamental purpose of the IMD exclusion. Either the exclusion was intended to deny FFP for facilities treating primarily people with a mental disease, or it was intended to deny FFP for a broad class of institutions treating such people, while still offering FFP for alternative treatment facilities. Agency expertise would not be particularly useful in deciding this question of statutory construction. Further, as the court has noted, the Board itself indicated that it understood the regulatory phrase "overall character" as comprehending factors other than merely the composition of the resident population, even though its determination in fact did not incorporate other factors. It is not clear that HHS has a single well-defined interpretation of the IMD exclusion, so deference is particularly inappropriate.

As the Eighth Circuit and the district court in Connecticut held, the Board used criteria fundamentally incompatible with the purpose of the IMD exclusion in characterizing the ICFs here as IMDs. The Board's decision therefore was not in accordance with law, and the court holds the Board's decision to be unlawful and sets it aside. 5 U.S.C. §706(2)(A).⁵

⁵ The Eighth Circuit set aside the Board's decision on the stated basis that it was unsupported by substantial evidence on the record as a whole. 718 F.2d at 866. Illinois has not argued for this standard of review, which applies to record review of an agency hearing provided by statute. 5 U.S.C. § 706(2)(E). It is not clear to the court that the hearing before the Board, under 45 C.F.R. Pt. 16 (1983), was such a hearing.

A final question to be considered is the scope of relief available to Illinois. Paragraph A of Illinois' prayer for relief seeks a declaratory judgment setting aside the Board's decision, and such relief clearly is available and will be ordered. Paragraphs B and C request relief which may not be available. First, the requested injunction may be broader than appropriate. The court sets aside the Board's decision, but the court does not hold that the facilities in question are not IMDs. HHS is free to undertake another review using standards consistent with Congressional intent. Second, and more important, it is not clear to the court whether paragraphs B and C in effect request money damages. The Eighth Circuit expressly held that jurisdiction to award such relief lies exclusively in the U.S. Claims Court. 718 F.2d at 857-860. Illinois shall file a statement within 21 days, either dropping its request for further relief (beyond a declaratory judgment setting side the Board's decision), or setting forth a schedule, agreed upon by the parties, for briefing the availability of the other relief requested.

Accordingly, the court accepts the recommendation of the Magistrate. Illinois' motion for summary judgment is granted, and HHS's motion for summary judgment is denied. The court holds that Decision No. 231 of the Grant Appeals Board was not in accordance with law and should be set aside. Illinois is to file a statement concerning relief within 21 days of the entry of this order.

It is so ordered.

SUSAN GETZENDANNER
United States District Judge

March 20, 1984

APPENDIX A
**IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT
OF ILLINOIS
EASTERN DIVISION**

NO. 82 C 1349

STATE OF ILLINOIS,
BY THE ILLINOIS DEPARTMENT OF PUBLIC AID,
Plaintiff,

v.

UNITED STATES DEPARTMENT OF HEALTH
AND HUMAN SERVICES AND MARGARET HECKLER,
SECRETARY OF HEALTH AND HUMAN SERVICES,
Defendants.

TO: HONORABLE SUSAN GETZENDANNER, *JUDGE*
UNITED STATES DISTRICT COURT

HONORABLE JUDGE:

**REPORT AND RECOMMENDATION
of Magistrate James T. Balog**

I. INTRODUCTION

This matter comes before this Court on the parties' cross-motions for summary judgment. The Plaintiff, the State of Illinois (Illinois), has filed this action for declaratory and injunctive relief against the implementation of Decision No. 231 of the Departmental Grant Appeals Board of the Department of HHS (HHS). Illinois asserts jurisdiction under 28 U.S.C. §§ 1331, 1361, and 2201. Further, Illinois claims that judicial review of the Board's decision is authorized by 5 U.S.C. §§ 701-706.

Under Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.*, Illinois received payments from HHS to cover a percentage of the costs incurred in providing various types of medical assistance to the needy, including institutional services in intermediate care facilities (ICFs). These payments are called federal financial participation (FFP). From October 1, 1976, through September 30, 1978, numerous facilities within Illinois were certified as ICFs and thereby eligible for FFP under the Act. Among these facilities were the nine facilities involved in the case at bar.¹ During the aforementioned time-period, Illinois claimed and received FFP for expenditures it made in connection with the services rendered to the Medicaid-eligible residents of the nine ICFs. On March 5, 1979, the Health Care Financing Administration (HCFA) of HHS issued an audit report. ("Report on Review of Institutions for Mental Diseases Under the Medicaid Program" attached as 'Exhibit A' to Brief in Support of Defendants' Cross-Motion for Summary Judgment and In Opposition to Plaintiff's Motion for Summary Judgment [hereinafter cited as HCFA Audit Report].) This report concluded that the nine facilities were not really ICFs, but rather "institutions for mental diseases" (IMDs), and that the services rendered to the residents of these nine facilities were ineligible for FFP under the Medicaid program. HHS then moved to disallow all FFP for expenditures made by Illinois during the 1976-1978 period; this entailed the recoupment of \$4,261,162.00 paid to Illinois. Illinois applied to the Departmental Grant Appeals Board (Board) for review of the disallowance decision. After having consolidated Illinois' application with those of California, Connecticut, and Minnesota, the Board issued Decision No. 231 upholding the retroactive disallowance by the HCFA of the FFP paid to Illinois for the services provided to the residents of the nine facilities. Having exhausted all of its administrative remedies, Illinois filed this cause of action.

¹ The nine facilities are the Clayton Residential Home, the Grasmere Residential Home, the Traemour House, the Pembridge House, the Chateau Waukegan, the Central Plaza, the Stratford Home, the Evanston-Ridgeview, and the Kankakee Terrace.

II. JURISDICTION

Some confusion occurred as to the proper forum for this action. In addition to filing the instant suit in the District Court, Illinois petitioned the Court of Appeals for the Seventh Circuit to review the decision of disallowance. The Seventh Circuit held that the District Court possesses jurisdiction to review this disallowance. *Illinois v. Schweiker*, Nos. 82-1175 and 82-1752 (7th Cir. May 6, 1983). Thus, this Court may properly hear this suit. See *Minnesota v. Schweiker*, Civil No. 4-82-155 (D. Minn. Aug. 15, 1982); *Connecticut v. Schweiker*, Civil No. H-82-146 (D. Conn. Feb. 17, 1983).

III. STANDARD OF REVIEW

This action seeks judicial review of a final administrative decision. The Administrative Procedure Act, 5 U.S.C. § 706,² limits the extent of this Court's reviewing authority. In examining this statute's restrictions, the Supreme Court has

² 5 U.S.C. § 706 provides:

To the extent necessary to decision and when presented, the reviewing court shall decide all relevant questions of law, interpret constitutional and statutory provisions, and determine the meaning or applicability of the terms of an agency action. The reviewing court shall—

- (1) compel agency action unlawfully withheld or unreasonably delayed; and
- (2) hold unlawful and set aside agency action, findings, and conclusions found to be
 - (A) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law;
 - (B) contrary to constitutional right, power, privilege, or immunity;
 - (C) in excess of statutory jurisdiction, authority, or limitations, or short of statutory right;
 - (D) without observance of procedure required by law;
 - (E) unsupported by substantial evidence in a case subject to sections 556 and 557 of this title or otherwise reviewed on the record of an agency hearing provided by statute; or
 - (F) unwarranted by the facts to the extent that the facts are subject to trial de novo by the reviewing court.

In making the foregoing determinations, the court shall review the whole record or those parts of it cited by a party, and due account shall be taken of the rule of prejudicial error.

focused in on two key questions to be asked by the reviewing court: (1) whether the agency acted within the scope of its authority and (2) whether the agency's decision was arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law. *Citizens To Preserve Overton Park, Inc. v. Volpe*, 401 U.S. 402, 415-416 (1971). The first question entails an analysis of the agency's action vis-a-vis the legislation defining its jurisdiction. As to the second question, "the court must consider whether the decision was based on a consideration of the relevant factors and whether there has been a clear error of judgment." *Id.* at 416. Where the agency's action involves the interpretation of a statute which it administers, that interpretation generally deserves deference. *Schweiker v. Gray Panthers*, 453 U.S. 34 (1981). However, the extent of that deference depends upon "the nature of the agency's interpretation. Unofficial and unpublished agency interpretations are not given the same deference as more official pronouncements." *Minnesota v. Schweiker*, *supra*, slip op. at 6, citing *Morton v. Ruiz*, 415 U.S. 199 (1974). With these principals stated, this Court will now examine the statute involved in this suit.

IV. STATUTORY AND REGULATORY SCHEME

42 U.S.C. § 1396b provides that HHS shall pay to each State, which has a plan approved under 42 U.S.C. § 1396a, "an amount equal to the Federal medical assistance percentage . . . of the total amount expended . . . as medical assistance under the State plan. . . ." The statute defines "medical assistance" to include inpatient hospital services, skilled nursing facility (SNF) services, and intermediate care facility (ICF) services unless those services are performed in an institution for mental diseases (IMD). 42 U.S.C. § 1396d(a). Such services, when performed in an IMD, are the exclusive responsibility of the State. While the statute defines what constitutes an ICF,³ it is silent as to an IMD. By regulation, HHS has defined an IMD.

³ The term "intermediate care facility" refers to:

an institution which (1) is licensed under State law to provide, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment which a hospital or

(footnote continues)

"Institution for mental diseases" means an institution that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for the mentally retarded is not an institution for mental diseases.

42 C.F.R. § 435.1009 (1982). In spite of this definition, the parties dispute that which Congress intended by the term "IMD". Illinois argues that the term "IMD" encompasses only state mental hospitals or their private equivalents. (Brief in

(footnote continued)

skilled nursing facility is designed to provide, but who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities, (2) meets such standards prescribed by the Secretary as he finds appropriate for the proper provision of such care, (3) meets such standards of safety and sanitation as are established under regulation of the Secretary in addition to those applicable to nursing facilities under State law, and (4) meets the requirements of section 1395x(j)(14) of this title with respect to protection of patients' personal funds. The term "intermediate care facility" also includes any skilled nursing facility or hospital which meets the requirements of the preceding sentence. The term "intermediate care facility" also includes a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts, but only with respect to institutional services deemed appropriate by the State. The term "intermediate care facility" also includes any institution which is located in a State or an Indian reservation and is certified by the Secretary as meeting the requirements of clauses (2), (3), and (4) of this subsection and providing the care and services required under clause (1). With respect to services furnished to individuals under age 65, the term "intermediate care facility" shall not include, except as provided in subsection (d) of this section, any public institution or distinct part thereof for mental diseases or mental defects.

42 U.S.C. § 1396d(c).

Support of Plaintiff's Motion for Summary Judgment, pp. 22-36.) Because the nine facilities in question are not (and never were) state mental hospitals or their private equivalents, Illinois concludes that they cannot be classified as IMDs. HHS contends that the term "IMD" is sufficiently broad to subsume hospitals, SNFs, and ICFs. (Brief in Support of Defendants' Cross-Motion for Summary Judgment and In Opposition to Plaintiff's Motion for Summary Judgment, pp. 16-26.)

After conducting its own independent review of the statute, the relevant legislative history, and the pertinent case-law, this Court concludes that Congress intended the term 'institution for mental diseases' "to refer to those institutions which [provide] long-term care for the mentally ill by administering psychiatric treatment for its residents on the premises." *Minnesota v. Schweiker*, *supra*, slip op. at 15. This conclusion focuses upon the nature and degree of care provided by the facility in question. It finds support in the case of *Legion v. Richardson*, 354 F.Supp. 456 (S.D.N.Y.), *aff'd sub nom. Legion v. Weinberger*, 414 U.S. 1058 (1973). The *Legion* court upheld the Medicaid statute against an equal protection claim, stating that the statute "distinguishes between medically indigent persons who require short-term care and those who require long-term care." *Id.* at 459. The *Legion* court discovered in the legislative history the intent of Congress to leave the responsibility for long-term care of patients in public mental institutions with the States. See S.Rep. No. 404, 89th Cong., 1st Sess., 144, *reprinted in* [1965] U.S. Code Cong. & Adm. News 2084. See also 117 Cong. Rec. 44721 (1971) (remarks of Sen. Long). Thus, the determination of whether or not a facility is an IMD centers upon the nature and extent of services being performed in the facility.

V. HHS' ACTION IN THIS CASE

In November of 1978, the Medicaid Regional Office of the HCFA undertook a review to determine whether any facilities certified as SNFs or ICFs met the definition of an IMD. In performing this review, the Medicaid Regional Office relied on

three documents which comprise part of the Field Staff Information and Instruction Series (FSIIS). These three documents set out eight criteria that form "the basis for a determination that a facility is an institution for mental diseases." (HCFA Audit Report, p. 2.) These criteria are as follows:

- (1) It is licensed as such;
- (2) It is advertised as such; or
- (3) If more than 50 per cent of the patients have a diagnosis of mental disease, as defined in the *International Classification of Diseases*, Eighth Revision (codes used from this Source Document are given in Attachment 4);
- (4) Used by mental hospitals for alternative care;
- (5) Patients who were accepted directly from the community but had been in mental hospitals;
- (6) Proximity to State mental institutions (25 mile radius);
- (7) Age distribution uncharacteristic of nursing home patients;
- (8) Basis of Medicaid eligibility for patients under age 65 due to mental disability.

(HCFA Audit Report, pp. 2-3.) With these criteria in hand, personnel from the Medicaid Regional Office began contacting the Illinois Department of Mental Health and Developmental Disabilities (IDMH/DD), the Illinois Department of Public Aid (IDPA), and the Illinois Department of Public Health (IDPH) to gather information concerning nursing homes used for placement of the mentally ill. Preliminary findings revealed that twenty facilities potentially met the definition of an IMD. Further review of records resulted in the identification of eleven facilities as probable IMDs. The next step of the audit process entailed two employees of the Medicaid Regional Office, neither of whom were medical personnel, examining the medical review, the independent professional review, and the utilization review documents for each Medicaid patient at each facility. These documents included the diagnosis and treatment as recorded in each patient's medical record. (HCFA Audit

Report, p. 5.) Where the primary reason given for a patient's institutionalization was a mental dysfunction, the Medicaid Regional Office considered the patient to be mentally ill. Then, based on the eight criteria noted above, the Medicaid Regional Office found nine of the facilities to be IMDs. (HCFA Audit Report, p. 6.)

VI. DISCUSSION

The review made by the Medicaid Regional Office and resulting in the HCFA Audit Report directed its attention toward the diagnosis of the individuals in the nine facilities. This analysis almost completely ignored the type of services rendered by the facilities in question. As to eight of the nine facilities in question, the HCFA Audit Report merely states that "the primary nature of care rendered . . . is geared toward [individuals/patients] with mental illnesses." (HCFA Audit Report, pp. 7-18.) Of these eight facilities, the Report delves no deeper into the services rendered by five. As to the remaining three facilities, the Report gives superficial treatment to the type of service rendered: e.g., vocational rehabilitation services, community workshop program, and counselling services. The Report states nothing about long-term care of the administration of psychiatric treatment. This action—the determination on the basis of diagnosis that the nine facilities are IMDs—by HHS disregards the statute and the caselaw interpreting the statute. As such, this action is both arbitrary and capricious; it does "not square with Congress' understanding of the statute," and "conflicts with the Medicaid philosophy of nondiscrimination on the basis of diagnosis, as well as with HHS' policy of encouraging deinstitutionalization." *Minnesota v. Schweiker*, *supra*, slip op. at 15.

VII. CONCLUSION

For the reasons stated herein, IT IS RECOMMENDED that the Plaintiff's Motion for Summary Judgment be GRANTED and that the Defendants' Cross-Motion for Summary Judgment be DENIED.

Respectfully submitted,

JAMES T. BALOG
United States Magistrate

DATE: SEPTEMBER 27, 1983.

The parties may serve and file written objections to this Report and Recommendation within ten (10) days.

Copies have, this date, been mailed to:

ELLIN P. BREWIN
Special Asst. Attorney General
130 North Franklin Street
Suite 300
Chicago, Illinois 60606
Attorney for Plaintiff

DAN K. WEBB
United States Attorney
219 South Dearborn Street
Chicago, Illinois
ATTN: JAMES J. KUBIK
Asst. United States Attorney
Attorney for Defendants.

SEP 28 1984

ALEXANDER L. STEVAS,
CLERK

No. 83-2136

In the Supreme Court of the United States

OCTOBER TERM, 1984

STATE OF CONNECTICUT, DEPARTMENT OF
INCOME MAINTENANCE, PETITIONER

v.

MARGARET M. HECKLER, SECRETARY OF
HEALTH AND HUMAN SERVICES, ET AL.

*ON PETITION FOR A WRIT OF CERTIORARI TO
THE UNITED STATES COURT OF APPEALS FOR
THE SECOND CIRCUIT*

BRIEF FOR THE RESPONDENTS IN OPPOSITION

REX E. LEE

Solicitor General

RICHARD K. WILLARD

Acting Assistant Attorney General

Department of Justice

Washington, D.C. 20530

(202) 633-2217

QUESTION PRESENTED

Whether only a traditional mental hospital can be classified as an "institution for mental diseases" (IMD) under the Medicaid statute, so that the Secretary of Health and Human Services is barred from designating an "intermediate care facility" as an IMD for purposes of applying the statutory exclusion of Medicaid coverage for services to persons in an IMD.

TABLE OF CONTENTS

	Page
Opinions below	1
Jurisdiction	1
Statute involved	1
Statement	3
Argument	7
Conclusion	12

TABLE OF AUTHORITIES

Cases:

<i>Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.</i> , No. 82-1005 (June 25, 1984)	8
<i>Harris v. McRae</i> , 448 U.S. 297	3
<i>Minnesota v. Heckler</i> , 718 F.2d 852	8, 9, 10, 11
<i>Schweiker v. Gray Panthers</i> , 453 U.S. 34	3, 9
<i>Schweiker v. Wilson</i> , 450 U.S. 221	8, 10

Statute and regulations:

Social Security Act, Tit. XIX, 42 U.S.C. (& Supp. V) 1396 <i>et seq.</i>	3
42 U.S.C. (& Supp. V) 1396a	3
42 U.S.C. (& Supp. V) 1396b(a)	3
42 U.S.C. (& Supp. V) 1396d(a)	1, 3
42 U.S.C. 1396d(a)(1)	4, 8
42 U.S.C. 1396d(a)(4)(A)	4, 8

Statute and regulations—Continued:

42 U.S.C. 1396d(a)(15)	4, 8
42 U.S.C. (Supp. V) 1396d(1)(18)(B)	4
42 U.S.C. (Supp. V) 1396d(c)	2
42 C.F.R. 435.1009(e)(2)	4, 11
45 C.F.R. Pt. 16	6

In the Supreme Court of the United States

OCTOBER TERM, 1984

No. 83-2136

STATE OF CONNECTICUT, DEPARTMENT OF
INCOME MAINTENANCE, PETITIONER

v.

MARGARET M. HECKLER, SECRETARY OF
HEALTH AND HUMAN SERVICES, ET AL.

*ON PETITION FOR A WRIT OF CERTIORARI TO
THE UNITED STATES COURT OF APPEALS FOR
THE SECOND CIRCUIT*

BRIEF FOR THE RESPONDENTS IN OPPOSITION**OPINIONS BELOW**

The opinion of the court of appeals (Pet. App. 1a-16a) is reported at 731 F.2d 1052. The opinion of the district court (Pet. App. 1c-25c) is reported at 557 F. Supp. 1077.

JURISDICTION

The judgment of the court of appeals (Pet. App. 1b-2b) was entered on March 30, 1984. The petition for a writ of certiorari was filed on June 28, 1984. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATUTE INVOLVED

1. Section 1905(a) of the Social Security Act, as amended, 42 U.S.C. (& Supp. V) 1396d(a), provides in pertinent part:

(1)

(a) The term "medical assistance" means payment of part or all of the cost of the following care and services

* * * —

(1) inpatient hospital services (other than services in an institution for tuberculosis or mental diseases);

* * * * *

(4)(A) skilled nursing facility services (other than services in an institution for tuberculosis or mental diseases) for individuals 21 years of age or older; * * *

* * * * *

(14) inpatient hospital services, skilled nursing facility services, and intermediate care facility services for individuals 65 years of age or over in an institution for tuberculosis or mental diseases;

(15) intermediate care facility services (other than such services in an institution for tuberculosis or mental diseases) for individuals who are determined * * * to be in need of such care;

* * * * *

(18) * * * except as otherwise provided in paragraph (16), such term does not include * * * (B) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for tuberculosis or mental diseases.

2. Section 1905(c) of the Act, as amended, 42 U.S.C. (Supp. V) 1396d(c), provides in pertinent part:

(c) For purposes of this subchapter the term "intermediate care facility" means an institution which (1) is licensed under State law to provide, on a regular basis, health-related care and services to individuals who do

not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities * * *. The term "intermediate care facility" also includes any skilled nursing facility or hospital which meets the requirements of the proceeding [sic] sentence. * * * With respect to services furnished to individuals under age 65, the term "intermediate care facility" shall not include, except as provided in subsection (d) of this section, any public institution or distinct part thereof for mental diseases or mental defects.

STATEMENT

1. The Medicaid program was established pursuant to Title XIX of the Social Security Act, 42 U.S.C. (& Supp. V) 1396 *et seq.*, "for the purpose of providing federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons." *Harris v. McRae*, 448 U.S. 297, 301 (1980). To participate in the program, a state must develop a Medicaid plan that is consistent with the requirements of Title XIX and federal regulations. 42 U.S.C. (& Supp. V) 1396a. See *Schweiker v. Panthers*, 453 U.S. 34, 35 (1981). Following approval of the plan by the Secretary of Health and Human Services, the state is entitled to federal financial assistance for providing medical care to eligible individuals who are covered by the state plan. 42 U.S.C. (& Supp. V) 1396(a).

The Medicaid statute specifically excludes from coverage services provided to any person more than 21 and under 65 years of age who is a patient in an "institution for mental diseases" (IMD). 42 U.S.C. (& Supp. V) 1396d(a). The statute defines "medical assistance" for which federal financial participation is available to include inpatient hospital

services, skilled nursing facility services and intermediate care facility (ICF) services, other than services provided in an institution for mental diseases. 42 U.S.C. 1396d(a)(1), (4)(A) and (15). Payments for services to individuals under age 65 who are patients in an institution for mental diseases (other than inpatient psychiatric care for persons under age 21) are further specifically prohibited by 42 U.S.C. (Supp. V) 1396d(a)(18)(B).

The Medicaid statute does not define the term "institution for mental diseases." The Secretary, however, has defined an IMD as

an institution that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.

42 C.F.R. 435.1009(e)(2). The Secretary has supplemented this definition with a series of field staff instructions that describe the relevant criteria to be considered in determining whether or not the overall character of a facility is that of an IMD.¹

¹These criteria instruct audit teams to focus on the following characteristics of the institution under review (Pet. App. 5a n.2):

1. Licensed as a mental institution.
2. Advertised as a mental institution.
3. More than 50% of the patients have a disability in mental functioning.
4. Used by mental hospitals for alternative care.

2. The State of Connecticut brought this action in the United States District Court for the District of Connecticut, seeking review of a decision by the Department of Health and Human Services (HHS) disallowing federal financial assistance claimed by Connecticut under the Medicaid program for services provided to persons in Middletown Haven Rest Home, a private long-term care facility. The facility had been certified by the State as an ICF during the fiscal quarters at issue here, from January 1977 through September 1979. The State received federal financial assistance for payments it made to the institution during those quarters.

a. The certification of Middletown Haven as an ICF came under scrutiny in December 1979, when an audit team from HHS undertook a study of its patient records (Pet. App. 4a-5a). The study was conducted as part of an investigation by HHS to determine whether certain states, including Connecticut, "were discharging patients from mental hospitals and arranging their placement in ICF's in order to circumvent the Medicaid exclusion for patients under 65 in IMD's" (*id.* at 5a). Applying the criteria developed by HHS to supplement the IMD definition in its regulations (see note 1, *supra*), the audit team determined that Middletown

5. Patients who may have entered mental hospitals are accepted directly from the community.
6. Proximity to State mental institutions (within a 25 mile radius).
7. Age distribution uncharacteristic of nursing home patients.
8. Basis of Medicaid eligibility for patients under 65 is due to mental disability.
9. Hires staff specialized in the care of the mentally ill.
10. Independent professional reviews conducted by state teams report a preponderance of mental illness among patients in the facility.

Haven was an IMD on the basis of the following facts (Pet. App. 5a; Administrative Record, Tab 23, at 18, 36-37):

1. Seventy-seven percent of the patients had a major mental illness that was a substantial part of their need for ongoing care.
2. More than 50% of the patients had been admitted directly from state mental hospitals.
3. The facility is located only three miles from a state mental hospital and was used as an alternative placement for the hospital.
4. Sixty-four percent of the population was between the ages of 22 and 64, in contrast to the average age of 82 in the general nursing home population.
5. The facility's license from the State contained a "psychiatric rider" authorizing it to "care for persons with certain psychiatric conditions."
6. The facility advertised itself to the community and to potential sources of referral as a facility specializing in mental diseases.
7. The facility hired professional staff, including three psychiatrists, who specialized in the care of the mentally ill.

After reviewing the report of the audit team, the Health Care Financing Administration disallowed the reimbursement claimed by Connecticut for the cost of services provided to patients at Middletown Haven.

b. Connecticut appealed the disallowance to the HHS Departmental Grant Appeals Board pursuant to 45 C.F.R. Pt. 16. The Connecticut appeal was consolidated with the

appeals of three other states (Minnesota, Illinois and California) seeking review of findings that certain facilities in those states were IMDs. The Board upheld all of the disallowances, finding substantial evidence in the record that the "overall character" of each of the facilities was such that it met the regulatory definition of an IMD (Pet. App. 1d-61d). The Board's decision constituted the final agency decision.

c. Connecticut sought judicial review of the Secretary's decision in the district court. The district court granted Connecticut's motion for summary judgment (Pet. App. 1c-25c). It held that the IMD exclusion in the Medicaid statute "excludes only care in mental hospitals, meaning care in facilities which, at the least, provide total care to mental patients" (*id.* at 25c).

The court of appeals reversed (Pet. App. 1a-16a). Relying on the language and legislative history of the IMD exclusion, the court rejected petitioner's contention that "the IMD exclusion was intended to foreclose federal financial assistance only for services provided in traditional state mental hospitals" (*id.* at 7a). Instead, the court concluded that Congress intended the IMD exclusion "to block the use of Medicaid funds to help pay for the care of the mentally ill under age 65 in a broad range of institutions subsumed under the label 'institutions for mental diseases,' including ICF's" (*id.* at 15a). Consequently, the court held that "the IMD definition adopted by HHS and supplemented by its internal criteria reasonably implements Congress' intent" (*ibid.*).

ARGUMENT

Petitioner contends — as it did in the court of appeals — that IMDs and ICFs "are mutually exclusive categories of institutions" (Pet. App. 7a) and that the IMD exclusion in the Medicaid statute was meant to apply only to traditional mental hospitals, not to facilities like ICFs that offer

a lower level of care. The court of appeals, in a thorough opinion on which we rely, correctly rejected this argument. Moreover, contrary to petitioner's assertion (Pet. 7-11), the holding below that an ICF can be classified as an IMD does not conflict with this Court's decision in *Schweiker v. Wilson*, 450 U.S. 221 (1981), or with the decision of the Eighth Circuit in *Minnesota v. Heckler*, 718 F.2d 852 (1983). Accordingly, review by this Court is not warranted.

1. It is well settled that an agency's construction of a statute it administers is entitled to considerable deference. A reviewing court need not conclude that the agency's construction is the only permissible one, or even the reading the court would have reached if the question initially had arisen in a judicial proceeding. Rather, so long as the agency's interpretation of the statute is a reasonable one, the court may not substitute its own construction for that of the agency. See *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, No. 82-1005 (June 25, 1984), slip op. 4-7. Here, the court of appeals correctly concluded that "the IMD definition adopted by HHS and supplemented by its internal criteria reasonably implements Congress' intent" (Pet. App. 15a).

Although the Medicaid statute does not define the term "institution for mental diseases," the statutory language supports the Secretary's position that IMDs and ICFs are not mutually exclusive. In defining the categories of medical assistance for which Medicaid reimbursement is available, the statute lists separately "inpatient hospital services," "skilled nursing facility services," and "intermediate care facility services," and contains a separate and unequivocal exclusion from *each* type of service for individuals in IMDs. See 42 U.S.C. 1396d(a)(1), 4(A) and (15). As the court of appeals observed (Pet. App. 10a), "these identical exclusions strongly imply that Congress contemplated that any

of the three types of facilities — the hospital, the skilled nursing facility and the ICF — might qualify under certain circumstances as an IMD." In addition, the court of appeals pointed out (*ibid.*) that

the definition of an ICF states that "the term 'intermediate care facility' shall not include . . . any public institution . . . for mental diseases or mental defects," 42 U.S.C. § 1396d(c), except for public ICFs "for the mentally retarded or persons with related conditions," *id.* § 1396d(d). Since the exclusion for IMD's does not distinguish between public and private facilities, the combination of Sections 1396d(a)(15), 1396d(c) and 1396d(d) makes sense only as a statement that ICF's which are IMD's are excluded from the definition except those public ICF/IMD's which care for the mentally retarded. In short, the provisions are meaningless unless some ICF's are IMD's and thus subject to the statutory exclusion.

Moreover, after an exhaustive review of the legislative history (Pet. App. 10a-15a), the court of appeals correctly concluded (*id.* at 15a) that Congress intended the IMD exclusion "to block the use of Medicaid funds to help pay for the care of the mentally ill under age 65 in a broad range of institutions subsumed under the label 'institution for mental diseases,' including ICF's. Congress was asked repeatedly to lift this exclusion in whole or in part and refused" (*ibid.*). Thus, the language and history of the statute show that the Secretary's reasonable interpretation of the term "institution for mental diseases" is fully consistent with congressional intent.

2. The decision of the court of appeals does not conflict with the decisions of this Court in *Schweiker v. Wilson*, *supra*, or of the Eighth Circuit in *Minnesota v. Heckler*, *supra*, on the question whether an ICF can be classified as

an IMD for purposes of applying the Medicaid statute's IMD exclusion.

In *Schweiker v. Wilson*, *supra*, the Court did not rule that IMDs and ICFs were mutually exclusive categories of institutions. Indeed, the Court did not even address the issue of the definition of the term "institution for mental diseases." Instead, the Court addressed the constitutionality, under equal protection principles, of a statute excluding from Supplemental Security Income benefits those residents of public mental institutions who are subject to the IMD exclusion. Petitioner therefore errs in relying (Pet. 10) on references in both the majority and dissenting opinions in *Wilson* to selected portions of the legislative history of the IMD exclusion, because that history merely confirms that a state mental hospital is an IMD — a fact clearly not at issue here and certainly not inconsistent with the notion that an ICF also can be classified as an IMD.

Similarly, in *Minnesota v. Heckler*, *supra*, the court did not hold that an ICF cannot qualify as an IMD. On the contrary, the Eighth Circuit specifically stated that IMD treatment may include the type of care provided by facilities that offer only ICF services — *i.e.*, " 'room and board' care which is not aimed at simultaneously providing active or therapeutic treatment leading to cure" (718 F.2d at 866; Pet. App. 23e).

To be sure, as petitioner points out (Pet. 8), the decisions of the courts of appeals in this case and in *Minnesota v. Heckler*, *supra*, differ to some extent concerning the criteria that the Secretary may use to determine whether an institution (including an ICF) warrants treatment as an IMD. The court below stated that "the IMD exclusion virtually compels HHS to focus on the nature of the illnesses treated rather than the care furnished" (Pet. App. 16a), whereas the Eighth Circuit stated that "the characterization of an IMD

must fundamentally center on the type of care or nature of services required, not on the mere presence in a facility of patients who have, or at one time did have, diagnoses of a mental disease" (718 F.2d at 863; Pet. App. 17e).

We believe that any issue arising from this difference in approach is not subsumed within the question presented by the petition and, in any event, is not of sufficient importance to warrant review by this Court. This is so because, as a practical matter, the Eighth Circuit's focus on "care and treatment" does not constitute a significant departure from the Second Circuit's focus on diagnoses. In most, if not all, cases (including this one), ICFs that qualify as IMDs under the Second Circuit's approach because they contain large numbers of patients who suffer from mental diseases will also be found to be IMDs because extensive mental health care and treatment would be required in such facilities. As the Eighth Circuit observed (718 F.2d at 866 n.27; Pet. App. 23e n.27 (emphasis in original)), "[t]he degree of care and treatment *required* by a patient's mental or physical condition should be equivalent to the degree of care and treatment *furnished* to the patient by a facility."² Indeed, the Secretary did not seek certiorari in *Minnesota v. Heckler*, *supra*, in large part because the Eighth Circuit's requirement of focusing on care and treatment was considered to be substantially consistent with the Secretary's regulation and supplemental criteria.³

²In this case, for example, the record clearly demonstrates that the facility at issue would qualify as an IMD under the Eighth Circuit's test because of the type of care provided to the patients. See page 6, *supra*.

³The Secretary's regulation defines an IMD as "an institution *that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases.*" 42 C.F.R. 435.1009(e)(2) (emphasis added). Most of the ten criteria that the Secretary uses to supplement her regulation in making the determination whether the overall character of an institution warrants treatment as an IMD do not focus on diagnoses. See Pet. App. 5a n.2.

CONCLUSION

The petition for a writ of certiorari should be denied.
Respectfully submitted.

REX E. LEE

Solicitor General

RICHARD K. WILLARD

Acting Assistant Attorney General

SEPTEMBER 1984

IN THE
Supreme Court of the United States

OCTOBER TERM, 1984

No. 83-2136

STATE OF CONNECTICUT, DEPARTMENT OF
INCOME MAINTENANCE,

Petitioner,

v.

MARGARET M. HECKLER, SECRETARY, and THE UNITED STATES
DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Respondents.

**ON PETITION FOR A WRIT OF CERTIORARI TO
THE UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT**

REPLY BRIEF OF THE PETITIONER

DONALD M. LONGLEY
Assistant Attorney General
90 Brainard Road
Hartford, Connecticut 06114

CHARLES A. MILLER*
MICHAEL A. ROTH
COVINGTON & BURLING
1201 Pennsylvania Avenue, N.W.
P.O. Box 7566
Washington, D.C. 20044
(202) 662-6000

Attorneys for Petitioner
State of Connecticut
Department of Income
Maintenance

* *Counsel of Record*

October 1984

TABLE OF AUTHORITIES

	<u>Page</u>
CASES:	
Connecticut v. Schweiker, 557 F. Supp. 1077 (D. Conn. 1984)	2
Minnesota v. Heckler, 718 F.2d 852 (8th Cir. 1983)	2
Woe v. Matthews, 408 F. Supp. 419 (E.D.N.Y. 1976)	2

IN THE
Supreme Court of the United States

OCTOBER TERM, 1984

No. 83-2136

STATE OF CONNECTICUT, DEPARTMENT OF
INCOME MAINTENANCE,

Petitioner,

v.

MARGARET M. HECKLER, SECRETARY, and THE UNITED STATES
DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Respondents.

REPLY BRIEF OF THE PETITIONER

Petitioner ("Connecticut") demonstrated in its Petition for a Writ of Certiorari that the federal courts are in direct conflict on the important issue of whether the limitation on Medicaid coverage for services in institutions for mental diseases ("IMD") extends generally to nursing homes known as intermediate care facilities ("ICFs"). Pet., pp. 7-9. The Courts of Appeals for the Second and Eighth Circuits were both required to address the identical issue in analyzing and interpreting the IMD limitation. Both courts were reviewing the same administrative action and the opposite results, reached upon consideration of the same relevant statutory prohibition and legislative history, will have a profound fiscal and programmatic impact nationwide.

Respondents' contention that there is no conflict among the federal courts and that any difference between the Second Circuit and Eighth Circuit courts regarding the scope of the IMD provision is of no importance is legally and logically unsupportable. Br. in Opp., pp. 10-11. Under the current state of the law, nursing homes (ICFs) caring for people with mental

conditions will be eligible for federal Medicaid funding if situated in the Eighth Circuit, while homes with precisely the same characteristics situated in Connecticut and the other Second Circuit states will be denied Medicaid funds. Homes situated in the other circuits remain in a state of uncertainty pending clarification of the conflict in the circuit court decisions to date. This is a real-life conflict in the law that cannot be brushed under the table as the respondents attempt to do.

Respondents' assertion that there is no significant difference in the analyses of the two circuit courts is unjustified. The Eighth Circuit court rejected DHHS' view that the definition of IMD turned essentially on the diagnoses of the residents of the facility and that there are no distinctions between mental hospitals and ICFs for IMD purposes. The court concluded that whether a facility is an IMD depends upon the nature of the services rendered by the facility.¹ It acknowledged a major difference in the level of care offered in ICFs. App. E, pp. 17e-18e, 22e-23e.² The Second Circuit court expressly rejected the Eighth Circuit court's reasoning (App. A, p. 6a n.4) and accepted the arguments of DHHS that any custodial facility participating in the Medicaid program could be an IMD based upon the diagnoses of the patients and without regard to the nature of the services provided by the facility.

¹ Both the District Court in this case (App. C, pp. 20c-21c) and the District Court in Illinois in an identical case (App. F, p. 3f) adopted a similar interpretation of the statute.

² Respondents seek to attribute to the Eighth Circuit court the statement that "IMD treatment may include the type of care provided by facilities that offer only ICF services," relying on the Court's reference to "room and board" care not aimed at providing "active or therapeutic treatment leading to cure." Br. in Opp., p. 10. This reflects a misunderstanding of the court's analysis. The court meant, in the cited passage, that a facility would be classified as an IMD if its residents required the intensive level of psychiatric or custodial care characteristic of mental hospitals, whether or not the facility actually met the needs of its patients. App. E, p. 23e; 718 F.2d at 866. This meaning is confirmed by the court's cross reference to an earlier portion of its opinion (App. E, pp. 18e-20e; see 718 F.2d at 863-64) and to *Connecticut v. Schweiker*, 557 F.Supp. at 1084-85 (App. C, pp. 12c-15c) and *Woe v. Matthews*, 408 F.Supp. 419, 422, 426-29 and note 23. See App. E, p. 23e. This meaning insures that an IMD cannot become eligible for federal Medicaid funding by *not* meeting the needs of its patients.

The differentiation in level or intensity of care of mentally ill patients, to which the Second Circuit court attached no significance, is critical to the overall statutory scheme for providing federal assistance to the needy mentally ill. A major purpose of the original Medicaid Act in 1965 was to encourage the development of less intensive settings for mentally ill people who did not require the strict regimen of a mental hospital. Pet., p. 5. The IMD provision, which served to restrict the availability of federal Medicaid funds for care in mental hospitals, was an important element of that scheme, for it fortified the express statutory aim of encouraging states to develop alternative care settings, such as nursing homes. See 42 U.S.C. § 1396a(a)(20). Facilities like Middletown Haven emerged in response to that federal inducement, and the effort now to recoup the Medicaid funds that were paid for services provided in that facility and others like it breaks faith with the overriding Congressional plan.³

Respondents' failure to appreciate the conflict in the circuit court decisions is reflected in the incorrect statement that Middletown Haven, the Connecticut facility in issue in this case, "would qualify as an IMD under the Eighth Circuit court's test." Br. in Opp., p. 11 n.2. Respondents base this statement on the characteristics of Middletown Haven itemized at page 6 of their Brief in Opposition. Yet the three facilities involved in the Eighth Circuit case exhibited comparable characteristics, and on the all-important criterion of percentage of patients diagnosed as mentally ill all three had a higher percentage of such patients than did Middletown Haven. Compare Br. in Opp., p. 6 with App. D, pp. 49d-51d. It cannot be doubted that Middletown Haven would not have been found to be an IMD under the Eighth Circuit court's decision.

³ It should be stressed that a lower level or intensity of care does not imply a reduced quality of care. Nursing home care of the mentally ill who do not require mental hospital treatment was regarded as a better response to patient needs. In this connection, it is significant that Middletown Haven was described by the responsible DHHS official on the audit review team as an "excellent facility" and an "ideal ICF." Jt. App. 76.

The conflict among the federal courts regarding the correct interpretation of the IMD exclusion from Medicaid is manifest and important. Whether or not federal Medicaid funds are available to help care for a needy nursing home patient with a diagnosis which includes some sort of mental illness should not depend upon the geographical location of the facility.

For the foregoing reasons and the reasons stated in the Petition, the Petition for a Writ of Certiorari should be granted.

Respectfully submitted,

DONALD M. LONGLEY
Assistant Attorney General
90 Brainard Road
Hartford, Connecticut 06114

CHARLES A. MILLER*
MICHAEL A. ROTH
COVINGTON & BURLING
1201 Pennsylvania Avenue, N.W.
P.O. Box 7566
Washington, D.C. 20044
(202) 662-6000

Attorneys for Petitioner
State of Connecticut
Department of Income
Maintenance

* *Counsel of Record*

October 1984

4
No. 83-2136

Office - Supreme Court, U.S.
FILED

JAN 2 1985

ALBONIEL STEVAS,
CLERK

IN THE
Supreme Court of the United States
OCTOBER TERM, 1984

STATE OF CONNECTICUT, DEPARTMENT
OF INCOME MAINTENANCE,
v. *Petitioner,*

MARGARET HECKLER, SECRETARY OF
HEALTH AND HUMAN SERVICES, ET AL.,
Respondents.

On Writ of Certiorari to the United States Court of Appeals
for the Second Circuit

BRIEF FOR
THE AMERICAN PSYCHIATRIC ASSOCIATION,
THE NATIONAL ASSOCIATION OF
STATE MENTAL HEALTH PROGRAM DIRECTORS,
THE AMERICAN HEALTH CARE ASSOCIATION, AND
THE NATIONAL MENTAL HEALTH ASSOCIATION
AS AMICI CURIAE SUPPORTING PETITIONER

PAUL LITWAK
44 Holland Avenue
Albany, New York 12229

R. EMMETT POUNDSTONE, III
P.O. Box 8710
Montgomery, Alabama 36193

*Of counsel for amicus the
National Ass'n of State Mental
Health Program Directors*

JOEL I. KLEIN *
PAUL M. SMITH
ONEK, KLEIN & FARR
2550 M Street, N.W.
Washington, D.C. 20037
(202) 775-0184

* Counsel of Record

QUESTION PRESENTED

Whether a limitation in the Medicaid law on use of federal funds to reimburse states for the care of patients in "institutions for mental diseases" should be confined to traditional mental hospitals or should be extended to cover newly developed "intermediate care facilities" that serve residents with mental conditions calling for a lesser level of care.

TABLE OF CONTENTS

	Page
Interest of Amici Curiae	1
Statement	3
Summary of Argument	4
Argument	6
I. LEGISLATIVE HISTORY DEMONSTRATES THAT THE LIMITATION ON MEDICAID REIMBURSEMENT OF "INSTITUTIONS FOR MENTAL DISEASES" WAS AIMED ONLY AT MENTAL "HOSPITALS" AND WAS NEVER INTENDED TO LIMIT COVER- AGE FOR "INTERMEDIATE CARE FACILI- TIES" SERVING THE MENTALLY ILL.....	7
A. IMDs and the Original Medicaid Program....	7
B. The 1967 Amendments: ICFs and the Deci- sion to Provide Long-Term Care	11
C. The 1971 Amendments: ICFs are Merged into Medicaid	14
D. Subsequent Indicia of Congressional Intent— The 1972 Amendments	17
E. The Second Circuit's Analysis of Legislative History	19
II. HHS'S POSITION UNDERMINES ANY SEN- SIBLE POLICY THAT CONGRESS IN- TENDED BY INCLUDING THE MENTALLY ILL IN THE ICF PROGRAM	23
III. THE DEPARTMENT'S RULE WOULD IM- POSE INTOLERABLE BURDENS ON STATE EFFORTS TO MEET THE NEEDS OF THE CHRONICALLY MENTALLY ILL	27
Conclusion	31

TABLE OF AUTHORITIES

Cases	Page
<i>Beltran v. Myers</i> , 451 U.S. 625 (1981)	15
<i>Minnesota v. Heckler</i> , 718 F.2d 852 (8th Cir. 1983)	4, 6, 25
<i>Schweiker v. Wilson</i> , 450 U.S. 221 (1981)	9, 10, 25
 <i>Statutes and Regulations</i>	
42 U.S.C. § 1396	11
42 U.S.C. § 1396a (a) (31)	27
42 U.S.C. § 1396d (a) (14)	3, 18
42 U.S.C. § 1396d (a) (15)	3, 14
42 U.S.C. § 1396d (a) (16)	18
42 U.S.C. § 1396d (c)	3, 14, 17
42 U.S.C. § 1396d (d)	17
42 U.S.C. § 1396d (h)	18, 27
Pub. L. No. 81-734, §§ 303 (a), 343 (a), 351, 64 Stat. 477 (1950)	7
Pub. L. No. 86-778, § 601 (f), 74 Stat. 924, 991 (1960)	7
Pub. L. No. 89-97, § 121 (a), 79 Stat. 351 (1965)	8
Pub. L. No. 89-97, § 221, 79 Stat. 356 (1965)	7
Pub. L. No. 90-248, § 250, 81 Stat. 920 (1968)	11, 12
Pub. L. No. 92-223, § 4 (a) (1) (C), 85 Stat. 809 (1971)	14
Pub. L. No. 92-223, § 4 (a) (2), 85 Stat. 809 (1971)	14, 17
Pub. L. No. 92-603, 86 Stat. 1329 (1972)	17, 18
42 C.F.R. § 435.1009 (1984)	4
34 Fed. Reg. 9782-84 (1969)	16
 <i>Bills</i>	
H.R. 17550, 91st Cong., 2d Sess. (1970)	16
H.R. 1, 92d Cong., 2d Sess. (1972)	19
 <i>Legislative Materials</i>	
H. Rep. No. 213, 89th Cong., 1st Sess (1965)	9
S. Rep. No. 404, 89th Cong., 1st Sess. (1965)	8, 9, 13, 21
S. Rep. No. 744, 90th Cong., 1st Sess. (1967)	12, 13
S. Rep. No. 1431, 91st Cong., 2d Sess. (1970)	12
S. Rep. No. 1230, 92d Cong., 2d Sess. (1972)	15

TABLE OF AUTHORITIES—Continued

	Page
Social Security; Medical Care for the Aged Amendments: Hearings on H.R. 11865 Before the Senate Comm. on Finance, 88th Cong., 2d Sess. (1964)	8, 9, 10
Social Security Amendments of 1967: Hearings on H.R. 12080 Before the Senate Comm. on Finance, 90th Cong., 1st Sess. (1967)	22
Social Security Amendments of 1970: Hearings on H.R. 17550 Before the Senate Comm. on Finance, 91st Cong., 2d Sess. (1970)	10, 16, 22
Social Security Amendments of 1971: Hearings on H.R. 1 Before the Senate Comm. on Finance, 92d Cong., 1st & 2d Sess. (1972)	10, 18, 21
111 Cong. Rec. 15805 (1965)	8
113 Cong. Rec. 32594 (1967)	11
113 Cong. Rec. 36321 (1967)	12, 13
116 Cong. Rec. 41804 (1970)	15
117 Cong. Rec. 44721 (1971)	12, 15
 <i>Other Materials</i>	
<i>Accreditation Manual for Long-Term Care Facilities</i> (JCAH 1980)	27
Comptroller General of the U.S., <i>Returning the Mentally Disabled to the Community: Government Needs to Do More</i> (GAO Report 1977)	26, 28, 29
<i>Consolidated Standards Manual for Child, Adolescent and Adult Psychiatric, Alcoholism and Drug Abuse Facilities</i> (JCAH 1981)	27
Goldman, et al., <i>Deinstitutionalization: The Data Demythologized</i> , 34 Hosp. & Community Psych. 129 (1983)	28
Goldman, <i>Long-Term Care for the Chronically Mentally Ill</i> (Urban Inst. report 1983)	29
Kohen & Paul, <i>Current Trends and Recommended Changes in Extended-Care Placement of Mental Patients: The Illinois System As a Case in Point</i> , 2 Schizophrenia Bull. 575 (1976)	8, 28
<i>Medicare and Medicaid Guide</i> (CCH)	23

TABLE OF AUTHORITIES—Continued

	Page
Staff of the Special Senate Comm. on Aging, 94th Cong., 2d Sess., <i>The Role of Nursing Homes in Caring for Discharged Mental Patients</i> (Comm. Print 1976)	25, 26, 29
Talbott & Lamb, "Summary and Recommendations," in <i>The Homeless Mentally Ill</i> (Amer. Psychiatric Ass'n Task Force Report, H.R. Lamb ed., 1984)	29
<i>Toward a National Plan for the Chronically Mentally Ill</i> (Report to the Secretary of HHS by the Steering Committee on the Chronically Mentally Ill, December 1980)	8, 26, 28

IN THE
Supreme Court of the United States

OCTOBER TERM, 1984

No. 83-2136

STATE OF CONNECTICUT, DEPARTMENT
OF INCOME MAINTENANCE,

v. *Petitioner,*

MARGARET HECKLER, SECRETARY OF
HEALTH AND HUMAN SERVICES, ET AL.,
Respondents.

On Writ of Certiorari to the United States Court of Appeals
for the Second Circuit

BRIEF FOR

**THE AMERICAN PSYCHIATRIC ASSOCIATION,
THE NATIONAL ASSOCIATION OF
STATE MENTAL HEALTH PROGRAM DIRECTORS,
THE AMERICAN HEALTH CARE ASSOCIATION, AND
THE NATIONAL MENTAL HEALTH ASSOCIATION
AS AMICI CURIAE SUPPORTING PETITIONER**

INTEREST OF AMICI CURIAE

The American Psychiatric Association ("APA"), founded in 1844, is the nation's largest organization of physicians who specialize in psychiatry. More than 30,000 of the nation's 37,000 psychiatrists are members. Psychiatrists have primary responsibility for treatment of the chronically mentally ill living in state institutions, nursing homes, and other settings. As a result, the association and its members are concerned about the availability of the range of appropriate settings serving the needs of this population. In particular, they have a direct interest in forestalling the increased homelessness and inappropriate placements that could result from a cut-off of Medicaid funds for intermediate care facilities serving the mentally ill.

The National Association of State Mental Health Program Directors ("NASMHPD") is the mental health

arm of the National Governors Association. Its membership is made up of the agencies in fifty-five states and territories that are responsible for government programs serving mentally disabled persons. NASMHPD members administer or support over 12,000 public and private facilities and programs of all kinds, including state institutions, intermediate care facilities, community mental centers, and day programs. One major aspect of the responsibilities shared by NASMHPD member agencies is care for the chronically mentally ill. The issue presented in this case, involving as it does Medicaid funding for one of the major residential options for the chronically mentally ill, is a matter of critical concern to these agencies.

The American Health Care Association ("AHCA") is the nation's largest federation of licensed nursing homes and allied long term health care facilities. It is comprised of 48 affiliated state associations whose more than 8,000 member facilities provide care for over 800,000 elderly, convalescent and chronically ill residents. AHCA members provide care and services under the Medicaid program to many of the patients who stand to lose coverage if the rule at issue here is upheld. These members have a direct interest in being able to provide appropriate care to the chronically mentally ill without facing such financial consequences.

The National Mental Health Association is the nation's largest consumer advocacy organization for mental health dedicated to promoting mental health, preventing mental illness, and improving the care and treatment of mentally ill individuals. The 650 Mental Health Association local chapters and state divisions, with more than one million citizen volunteers, work toward these goals through social action, education, advocacy and public information. The NMHA is vitally concerned about the effects that this case could have on the availability of appropriate, long-term care for the chronically mentally ill.¹

¹ The parties have agreed to filing of this brief *amici curiae*, and their letters of consent have been lodged with the Clerk.

STATEMENT

This case involves the eligibility for federal Medicaid reimbursement of "intermediate care facilities" that primarily serve chronically mentally ill patients. "Intermediate care facility" ("ICF") is a statutory term defined to mean a residential facility which provides "health-related care and services to individuals who do not require the degree of care and treatment which a hospital or a skilled nursing facility is designed to provide, but who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities." 42 U.S.C. § 1396d(c). The statute also requires that ICFs meet federally prescribed standards relating to quality of care and life-safety concerns. In practice, almost all ICFs are private nursing homes providing long-term care to the chronically disabled.

The dispute arises from a determination by the Department of Health and Human Services ("HHS") that most of the patients in an ICF in Connecticut, the Middletown Haven Rest Home, were ineligible for Medicaid coverage because it constituted an "institution for mental diseases" ("IMD"). This determination was based on the section of the Medicaid statute that provides coverage for ICF services "other than in an institution for tuberculosis or mental diseases." *Id.* § 1396d(a)(15). *See also id.* § 1396d(c). In a separate section, the statute also provides an exemption from the IMD exclusion for persons over age 65, who may receive ICF, skilled nursing, or hospital services in an IMD. *Id.* § 1396d(a)(14).

Middletown Haven ran afoul of the IMD requirement, as interpreted by HHS, because it primarily served mentally ill patients under age 65, many of whom had been admitted from state hospitals, and because it had staff with appropriate psychiatric training. These factors were found controlling because, in the Department's view, Medicaid coverage for the mentally ill under age 65 in ICFs is allowed only in facilities that do not themselves

become IMDs by unduly emphasizing care for patients with psychiatric disorders.²

Connecticut, on the other hand, maintained that the IMD exclusion was intended only to ensure that a particular group of facilities—i.e., mental hospitals—not receive Medicaid funds. It argued that the exclusion was simply irrelevant to the Medicaid eligibility of a second group of facilities—ICFs. The State, therefore, sought review of the federal action before the Grant Appeals Board, which upheld the Department's position, and disallowed some \$1.6 million in federal funds that had previously been paid. The district court then reversed. The Second Circuit, however, disagreed with the district court and reinstated the disallowance.³ In the view of *amici*, this decision contravenes clear legislative intent and must be reversed.

SUMMARY OF ARGUMENT

The basic issue in this case is whether the IMD exclusion should be read broadly, to bar coverage for care in any facility that primarily serves the mentally ill (including ICFs), or more narrowly to bar coverage only in traditional mental *hospitals*. Faced with the indisputable fact that Congress intended to cover mentally ill citizens of all ages in ICFs, HHS nevertheless takes the position that when "too many" such persons are placed in the same ICF, every patient under 65 in the facility becomes ineligible for Medicaid. To reach this conclusion, HHS has borrowed a concept—the IMD—that Congress used for another purpose and has attempted to

² The applicable regulation defines an IMD as "an institution that is primarily engaged in providing diagnosis, treatment or care of persons with mental disease . . ." 42 C.F.R. § 435.1009 (1984). The Secretary has interpreted this definition to include facilities like ICFs, in addition to traditional "mental institutions." See page 23 *infra*.

³ This created a conflict with the decision of the Eighth Circuit in *Minnesota v. Heckler*, 718 F.2d 852 (1983).

stretch it beyond its intended limit. In our view, this approach has little to recommend it in law or in logic.

I. The IMD exclusion was a feature of the original Medicaid statute in 1965, before there was any coverage at all for ICFs. At the time, Congress made clear that IMDs were mental hospitals and mental retardation institutions which, not surprisingly, cared exclusively for patients suffering from mental illness and mental retardation. The ICF program was enacted in 1967, and was originally not even a part of the Medicaid program. By its terms, it applied to persons needing care "because of their . . . mental condition," and contained no IMD exclusion. Its purposes were to provide an appropriate and humane alternative to state mental hospitals for the chronically mentally ill, while also providing residential coverage for the chronically physically disabled. When the ICF program was later merged into the Medicaid program in 1971, the intended purposes were not curtailed in any fashion. At no time, in short, did Congress ever suggest that an ICF would be transformed into an IMD because it reached a tipping point with respect to the number of mentally ill patients it served. See pp. 7-23 *infra*.

II. The position espoused by HHS is not only incompatible with the legislative history, it is also hard to square with any sensible policy that might be attributed to Congress. Since HHS acknowledges that Congress intended to cover the mentally and physically handicapped in ICFs irrespective of age, why would Congress want to exclude coverage for patients under age 65 only when more than half the patient's in a given ICF are mentally ill? Neither HHS nor the court below has been able to answer this basic question. On the other hand, HHS's approach would lead to two obviously unintended and manifestly undesirable effects. First, it would encourage the dispersal of the mentally ill among the larger ICF population by ruling out the option that may be much more appropriate for some patients—a specialized, psychiatrically oriented ICF. Second, by attaching the risk

of Medicaid decertification whenever a facility treats a substantial number of mentally ill people, the rule would lead to discrimination in the availability of ICF care to this group of patients whom Congress clearly intended to cover. See pp. 23-27 *infra*.

III.—Finally, we think it appropriate to point out the folly of any ruling that could serve to limit the alternative forms of care available to the chronically mentally ill outside of state hospitals. In the wake of a general shift away from the use of state mental hospitals for long-term care of the chronically ill, the states are already at a budgetary breaking point in their efforts to deal with this population. A cutback in federal support would only impose greater burdens on the states' efforts to build adequate alternative care systems for such persons. See pp. 27-30 *infra*.

ARGUMENT

The question of statutory interpretation presented here, while technical, ultimately involves the availability and quality of services that are needed by many of the hundreds of thousands of chronically mentally ill in this country. Each side in this dispute offers an interpretation that is consistent with the statutory language itself. This does not mean, however, that the Court should defer to Department's preferred interpretation. Where linguistic ambiguity exists, executive agencies have an obligation to take a look at what Congress sought to accomplish in an authorizing statute. Here, that necessary attention to congressional purposes was not paid.⁴ If it had been, it would have become apparent that HHS's position effectively rewrites the statute, rather than reasonably interpreting it.

⁴ Deference to the agency interpretation would be doubly inappropriate here, where HHS's interpretation was contained only in informal bulletins distributed within the Department almost ten years after the initiation of coverage for ICFs and five years after the incorporation of the program in Medicaid. See *Minnesota v. Heckler*, 718 F.2d 852, 862 (8th Cir. 1983).

I. LEGISLATIVE HISTORY DEMONSTRATES THAT THE LIMITATION ON MEDICAID REIMBURSEMENT OF "INSTITUTIONS FOR MENTAL DISEASES" WAS AIMED ONLY AT MENTAL "HOSPITALS" AND WAS NEVER INTENDED TO LIMIT COVERAGE FOR "INTERMEDIATE CARE FACILITIES" SERVING THE MENTALLY ILL.

The key term in this dispute—IMD—is not defined in the statute. In our view, this is because the term was universally understood to refer to mental hospitals and mental retardation institutions, and not to alternative care facilities like ICFs. The legislative history fully confirms this view.

A. IMDs and the Original Medicaid Program.

The Medicaid program, enacted in 1965, represented an expansion of existing categorical "public assistance" programs for the aged, blind and disabled. As part of that expansion Congress for the first time decided to provide coverage for persons disabled by mental illness, of all ages, in general hospitals. It did so by eliminating any exclusion based on a *diagnosis* of mental illness.⁵ Except for persons 65 and over, however, it retained an exclusion based on the *facility* involved—the rule barring coverage for patients in institutions for mental diseases that had been a part of the categorical assistance programs since 1950.⁶

As the term itself suggests, the sole purpose and effect of the IMD exclusion in 1965 was to bar coverage for mental *hospitals* and mental retardation institutions.⁷

⁵ See Pub. L. No. 89-97, § 221, 79 Stat. 356 (1965) (repealing exclusion of patients suffering from "psychosis"). Congress had already moved in this direction in 1960, by providing 12 days of coverage in general hospitals for the aged mentally ill. See Pub. L. No. 86-778, § 601(f), 74 Stat. 924, 991 (1960).

⁶ See Pub. L. No. 81-734, §§ 303(a), 343(a), 351, 64 Stat. 477 (1950).

⁷ We believe the term "institution for mental diseases" was chosen because Congress meant to include both mental hospitals and

The rule was so described repeatedly by sponsors and supporters of the bill.⁸ Indeed, it probably never occurred to anyone that the IMD bar might be extended outside the hospital arena. The only other "inpatient" care covered as of 1965 was in "skilled nursing homes." And at that time nursing homes that specialized in providing care for the mentally ill or retarded simply did not exist.⁹ Not surprisingly, therefore, there is no indication that Congress thought a skilled nursing home could ever be an IMD.¹⁰ More importantly, to the extent that any less intensive, *intermediate*-level facilities existed at all, they were not covered under Medicaid in any event—for anyone of any age. As a result, it is undisputed that the

state institutions for the mentally retarded. When Congress expanded Medicaid coverage in 1971 to include mental retardation institutions (but not mental hospitals) it did not change the term IMD. See p. 16, n.23 *infra*.

⁸ *E.g.*, S. Rep. No. 404, 89th Cong., 1st Sess. 144 (1965) (1965 Amendments authorized payments for aged persons in "hospitals for mental diseases"); Social Security; Medical Care for the Aged Amendments: Hearings on H.R. 11865 Before the Senate Comm. on Finance, 88th Cong., 2d Sess. 108 (1964) (testimony of Secretary Celebreeze, Dept. of H.E.W. ("these hospitals are public institutions"); 111 Cong. Rec. 15805 (1965) (remarks of Senator Ribicoff) (bill eliminates restriction on aid for "recipients . . . in mental or tuberculosis hospitals").

⁹ The shift of the chronically mentally ill from hospitals to nursing homes really only began in the mid 1960's. *Toward a National Plan for the Chronically Mentally Ill*, at 2-30 to -31 (Report to the Secretary of HHS by the Steering Committee on the Chronically Mentally Ill, December 1980); Kohen & Paul, *Current Trends and Recommended Changes in Extended-Care Placement of Mental Patients: The Illinois System As a Case in Point*, 2 Schizophrenia Bull. 575, 576 (1976).

¹⁰ The original statute generally covered "skilled nursing home services," while making clear that such services were not reimbursable if they took place "in an institution for tuberculosis or mental diseases." Pub. L. No. 89-97, § 121(a), 79 Stat. 351 (1965). As is apparent from this language, Congress was simply assuring that nursing home services provided in a mental hospital or retardation institution would not be reimbursed.

class of facilities excluded as IMDs in 1965 did not include any ICFs.

This means, of course, that HHS's present interpretation of the term IMD to include some facilities emphasizing intermediate care for the mentally ill is based, not on direct congressional intent, but on extrapolation from the terms of a provision originally aimed only at mental hospitals. One way to assess the validity of this extrapolation is to look at the underlying purpose of the original decision to exclude coverage in these hospitals.

Congress's decision to incorporate the IMD exclusion when it passed Medicaid in 1965 stemmed primarily from concerns about both the desirability and the expense of covering the thousands of chronic patients in large *state* institutions.¹¹ First, with the special exception of persons over 65,¹² Congress retained some residual commitment to the traditional notion, reflected in the older categorical assistance programs, that long-term care for the chronically mentally ill and retarded—then almost always in state institutions—was a state responsibility. *Schweiker v. Wilson*, 450 U.S. 221, 237 n.19 (1981); S. Rep. No. 404, 89th Cong., 1st Sess. 144 (1965); H. Rep. No. 213, 89th Cong., 1st Sess. 126 (1965). Second, Congress did not believe that the care typically offered by those institutions constituted appropriate treatment. It viewed these facilities as "warehouses" where inadequate custodial services were provided to patients requiring much

¹¹ See, *e.g.*, Social Security; Medical Care for the Aged Amendments: Hearings on H.R. 11865 Before the Senate Comm. on Finance, 88th Cong., 2d Sess. 108 (1964) (testimony of Secretary Celebreeze, Dept. of H.E.W.) ("The main reason for this exclusion is that most of these hospitals are public institutions . . .").

¹² Congress's decision to cover the aged in IMDs came in the context of a legislative program that, through Medicare and Medicaid, sought to provide quite comprehensive medical care to older citizens. In particular, Congress clearly had determined that it would provide long-term care to the aged who are chronically disabled, and sought to maximize the options available, including state mental institutions. See S. Rep. No. 404, 89th Cong., 1st Sess. 144-45 (1965).

more. *Schweiker v. Wilson*, *supra*, 450 U.S. at 241-42 (Powell, J., dissenting). As Senate Finance Committee Chairman Long put it in 1970, explaining the 1965 omission of IMD coverage for persons under age 65:

[W]e had a situation, and I fear that in some cases it might still be going on, where people were not being treated; they were just being locked up the way you would lock up prisoners or animals, just to separate them from society when treatment could have restored them to society as a productive member or at least restore them to a happy life where they could find some degree of serenity between now and the time God calls them home.

Social Security Amendments of 1970: Hearings on H.R. 17550 Before the Senate Comm. on Finance, 91st Cong., 2d Sess. 538 (1970). *See also* Social Security Amendments of 1971: Hearings on H.R. 1 Before the Senate Comm. on Finance, 92d Cong., 1st & 2d Sess. 931 (1972) (additional remarks by Chairman Long).

In sum, the retention of the IMD exclusion in 1965 reflected two congressional decisions: (1) a general judgment that states should retain a significant portion of the responsibility for long-term care for the chronically mentally ill, and (2) a specific determination that Medicaid should not support the care of younger people in large state mental institutions.¹³ As we shall see, the

¹³ To be sure, the IMD exclusion is not limited to state institutions, but the legislative history confirms that they were the prime concern. It also suggests that the inclusion of the other type of IMD, private psychiatric hospitals, was a kind of afterthought, apparently motivated by a desire not to appear to discriminate against state facilities at a time when private psychiatric hospitals cared for very few long-term chronic patients. *See* Social Security; Medical Care for the Aged Amendments: Hearings on H.R. 11865 Before the Senate Comm. on Finance, 88th Cong., 2d Sess. 108 (1964) (testimony of Secretary Celebrezze, Dept. of H.E.W.) ("The main reason for the exclusion is that most of these hospitals are public institutions and are supported by public funds. Nor did it seem reasonable to cover private but not public institutions.")

introduction of ICF coverage two years later represented a reversal of the former policy, but not of the latter.

B. The 1967 Amendments: ICFs and the Decision to Provide Long-Term Care.

In the 1967 Amendments to the Social Security Act, Congress for the first time voted to provide reimbursement for care in facilities providing services less intensive than those in hospitals or skilled nursing facilities. In that year, it chose to cover residential care for the aged, blind, and disabled residing in ICFs. It did so, not by amending Medicaid, but by adding a new section 1121 to an entirely different chapter of the Social Security Act.¹⁴ *See* Pub. L. No. 90-248, § 250, 81 Stat. 920 (1968).

There are several important points to understand about this original ICF program. First, unlike the original Medicaid program, it was intended to provide long-term, intermediate-level care where that was the appropriate choice. The coverage was aimed at those persons who require supervised care "because of their physical or mental condition (or both)," but who "do not have such an illness, disease, injury, or other condition as to require the degree of care and treatment which a hospital or skilled nursing home . . . is designed to provide." *Id.* As Senator Miller, one of the sponsors of the program,¹⁵ put it:

This provision of the bill merely recognizes the facts of life about custodial care in "extended care" facilities. These facts are that there are different levels of care now available and that not all patients need the same level of care; that those who need "skilled nursing home care" should receive it; that those who do not require such a high level of care should re-

¹⁴ Section 1121 was part of Title XI of the Act. Medicaid is contained in Title XIX, 42 U.S.C. § 1396 *et seq.*

¹⁵ *See* 113 Cong. Rec. 32594 (1967) (remarks of Chairman Long).

ceive what we have designated an "intermediate level of care". . . .

113 Cong. Rec. 36321 (1967).¹⁶

Second, there was no intention to exclude any ICFs on the ground that they served too many mentally ill or disabled patients. Not only did the ICF statute not contain an IMD exclusion,¹⁷ it expressly included "mental condition" as a basis for admission to an ICF, Pub. L. No. 90-248, § 250, 81 Stat. 920 (1968) (enacting § 1121(b) (2)). And in so doing, it incorporated the decision made in the original 1965 Medicaid statute to cover the mentally ill *of all ages* as long as they were not in mental hospitals. Indeed, the "deinstitutionalization" of the mentally ill—a process that was moving at an accelerated pace by 1967—was among the primary purposes of extending coverage to ICFs. See S. Rep. No. 1431, 91st Cong., 2d Sess. 147 (1970) (reprinted at 117 Cong. Rec. 44721 (1971)) (Section 1121 "was intended to provide a means for appropriate placement of patients professionally determined to be in need of health-related supportive institutional care but not care at the skilled nursing home or mental hospital level") (emphasis supplied).

The third key point concerning the ICF program follows from the first two. In funding ICFs, Congress had

¹⁶ See also S. Rep. No. 744, 90th Cong., 1st Sess. 188-89 (1967).

¹⁷ Eligibility for ICF care under section 1121 was generally tied to eligibility for income assistance under four titles of the Social Security Act: Title I (old age assistance), Title X (aid to the blind), Title XIV (aid to the permanently and totally disabled) and Title XVI (aid to the aged, blind or disabled). Pub. L. No. 90-248, § 250, 81 Stat. 920 (1968). These programs, in turn, did bar income assistance to residents of "public institutions" and to under-65 residents of IMDs. But section 1121 itself made it clear that these exclusions would not affect the eligibility of ICF residents to receive coverage under the new ICF program. Under the new program, the fact that a person was "receiving institutional services" in an ICF was to be totally disregarded in determining eligibility. *Id.* As a result, the characterization of a given ICF as a public institution or an IMD was an issue that had no relevance under section 1121.

in mind facilities that were different in kind from mental institutions. Two years after it excluded Medicaid coverage for the long-term care provided in large mental hospitals, it created this new program to provide long-term care in what were first described as "intermediate care homes." S. Rep. No. 744, 90th Cong., 1st Sess. 188 (1967). Congress thus altered its previous position on long-term coverage for the chronically mentally ill. But it still remained unwilling to fund long-term care in large state hospitals. Instead, it focused on a new kind of facility, the ICF, which is specifically viewed as a superior *alternative* to the mental institution for many people who were or had been hospitalized in such settings.¹⁸

In Congress's view, the essential difference between ICFs and mental hospitals turned on the scale and design of ICFs, which allowed for some guarantees that long-term, quasi-custodial care would be provided humanely and with an eye to individual needs. Above all, Congress sought to make a fresh start from the previous state efforts to provide long-term care in state hospitals. It then tied this new approach to guarantees designed to ensure appropriate placement decisions, hoping thereby to prevent a recurrence of the unfortunate "dumping" of the mentally ill that had sometimes occurred in the recent past. See 113 Cong. Rec. 36321 (1967) (remarks of Sen. Miller) ("Of course, we must assure that each patient is placed in the facility that meets his particular needs.")

In sum, when it came to the care of the mentally ill, the ICF was, from the beginning, specifically intended to be an alternative to the same mental institutions that were largely barred from Medicaid coverage under the

¹⁸ Congress had previously recognized that "nursing homes" represented a useful alternative to IMDs for the aged. See S. Rep. No. 404, 89th Cong., 1st Sess. 145-46 (1965) (states should promote "utilization of community mental health centers, nursing homes, and other alternative forms of care").

"IMD" exclusion.¹⁹ Having made the decision to cover care for mentally ill persons of all ages in these alternative facilities, Congress saw no reason to exclude facilities specializing in care of the mentally ill—as it had done with respect to mental *hospitals* under Medicaid. In our view, Congress never altered this fundamental policy.

C. The 1971 Amendments: ICFs are Merged into Medicaid.

The issue in this case only arose because, in 1971, Congress merged ICF coverage into Medicaid. It accomplished this transfer by amending 42 U.S.C. § 1396d to include ICF services among the categories making up "medical assistance." *Id.* § 1396d(a)(15), *added by* Pub. L. No. 92-223, § 4(a)(1)(C), 85 Stat. 809 (1971). It then supplied a lengthy definition of the term "intermediate care facility." *Id.* § 1396d(c), *added by* Pub. L. No. 92-223, § 4(a)(2), 85 Stat. 809 (1971).

Each of these new provisions incorporated the Medicaid IMD exclusion. Section 1396d(a)(15) simply provided that ICF services could not be provided in "an institution for mental diseases." Section 1396d(c) provided that for services to persons under 65, except those in specialized facilities for the retarded, the term "ICF" could not include any "public institution or distinct part thereof for mental diseases or defects." The incorporation of these exclusions, however, did not indicate any intent to bar coverage of ICFs that had previously been covered but were serving too many mentally ill persons. Rather, Congress's goal was to prohibit coverage of traditional mental hospitals under the guise of the ICF program.²⁰ The legislative history confirms this view.

¹⁹ For the physically disabled, ICFs were seen as an appropriate and economical alternative to "skilled" nursing homes. *See id.*

²⁰ We do not mean to suggest that the conversion of a former institutional building into an ICF is foreclosed in all cases. Reasonable departmental criteria arguably could allow this, consistently with congressional intent, as long as the physical plant, programs,

First, the amendments at issue here were consistently characterized as a "transfer" to Title XIX of the *existing* ICF program—a program that, as we have noted, contained no restriction on services to the mentally ill in ICFs. *E.g.*, 117 Cong. Rec. 44721 (1971) (reprinting Senate Report) ("The amendment also provides for the transfer of the intermediate care provisions from Title XI . . . to Title XIX (Medicaid)."); S. Rep. No. 1230, 92d Cong., 2d Sess. 321 (1972).

The purposes of the transfer were twofold: (1) to bring ICFs under the Medicaid quality standards, and (2) to *expand* coverage to all "medically indigent."²¹ *See id.*; 117 Cong. Rec. 44721 (1971) (reprinting Senate Report); 116 Cong. Rec. 41804 (1970) (Chairman Long describing an identical provision in a previous bill). There is not a shred of legislative history reflecting an intent to cut back on coverage for facilities commonly understood to be ICFs prior to 1971, based on the number of mentally ill people being served. On the contrary, the committee report specifically reiterated the importance of ICFs as alternatives to mental institutions:

The committee amendment is designed to make it clear that intermediate care coverage is for persons with health-related conditions who require care beyond residential care or boarding home care, and who, in the absence of intermediate care would require placement in a skilled nursing home or mental hospital.

117 Cong. Rec. 44721 (1971) (emphasis supplied).

patients, and admissions criteria in the new facility demonstrate a true adoption of the ICF approach.

²¹ The original ICF program was tied to eligibility for income assistance for the aged, blind and disabled. Medicaid covers not only these "categorically needy" but also (at state option) persons in the same categories with slightly higher incomes, who are unable to pay for medical care and thus are termed the "medically needy." *See, e.g., Beltran v. Myers*, 451 U.S. 625, 626 n. 1 (1981).

In the process of accomplishing the transfer of the ICF program in 1971, Congress did incorporate the IMD exclusion. Its goal, however, was not to shrink the ICF program but to forestall its expansion. Immediately after the adoption of the ICF program, there were efforts by some states to use the ICF concept as a means of gaining coverage for under-65 patients in traditional state mental institutions. Those efforts centered largely on certain public facilities serving the mentally retarded, which the states had labelled ICFs. *See* Social Security Amendment of 1970: Hearings on H.R. 17550 Before the Senate Comm. on Finance, 91st Cong., 2d Sess., 505-09, 511-15 (1970) (testimony of Dr. Kenneth Gaver representing NASMHPD). *See also id.* at 918-24 (testimony of Elizabeth Boggs, Nat'l Ass'n for Retarded Children). The validity of these efforts was controversial and the applicable regulations were ambiguous. *See* 34 Fed. Reg. 9782-84 (1969). As a result, even before the decision to transfer the ICF program to Medicaid, there had been proposals in Congress to amend Title XI to reaffirm the original conception of an ICF as something different from a large traditional institution. *See* H.R. 17550, 91st Cong., 2d Sess., § 225(b)(2) (1970).²² By incorporating the IMD rule in the new Medicaid ICF provision, Congress simply sought to maintain the same categories of coverage for the mentally ill under age 65 that had existed since the 1967 Amendments: acute care in general hospitals and appropriate long-term care for the chronically ill in ICFs rather than traditional mental hospitals.²³

²² This bill, as originally reported by the House Ways and Means Committee, would have made it clear that "the term 'intermediate care facility' shall not include any public institution (or distinct part thereof) for mental diseases or defects." In the Senate version of the bill, this provision was replaced with the very same language that, one year later, would be used by Congress to accomplish the transfer of the ICF program to Medicaid. H.R. 17550, 91st Cong., 2d Sess. § 269 (1970) (as reported by Senate Finance Committee).

²³ At the same time, Congress heeded pleas from various groups about the need for public institutional care for the mentally retarded. It created a new category of facility, the "intermediate

It is particularly instructive to realize in this regard that when Congress moved the ICF program into Medicaid in 1971, it elaborated for the first time on its understanding of IMDs by adding a proviso to the effect that "the term 'intermediate care facility' shall not include . . . any public institution . . . for mental diseases or defects," 42 U.S.C. § 1396d(c) (emphasis supplied).²⁴ Through this specific reference to "public institutions," Congress made plain that it was dealing with state mental hospitals, and not designing a rule that depended on whether an ICF had a particular number of mentally ill patients. The vast proportion of ICFs—including those that have a majority of mentally ill residents—are privately owned and operated, much like the facility at issue in this case. If, by transferring the ICF program in 1971, Congress had intended to exclude ICFs that primarily serve the mentally ill, it hardly would have focussed its concern on "public institutions" in the course of the very same statutory reorganization.

D. Subsequent Indicia of Congressional Intent—The 1972 Amendments.

The only subsequent indications of congressional intent concerning ICFs and IMDs came a year later, in the 1972 Amendments to the Social Security Act. Pub. L. 92-603, 86 Stat. 1329 (1972). These amendments made two changes, each of which, properly understood, makes it even clearer that ICFs are not limited by the IMD exclusion.

First, Congress again amended the definition of "medical assistance" to remedy a possible ambiguity, making it

care facility for the mentally retarded," which was specifically authorized to be a public institution. Pub. L. No. 92-223, § 4(a)(2), 85 Stat. 809 (1971) (adding 42 U.S.C. § 1396d(d)). Thus, while continuing to deny coverage for mental hospitals, Congress shifted course with respect to state mental retardation institutions, authorizing coverage for them for the first time.

²⁴ Public institutions for the retarded were exempted from this exclusion. *See* note 23 *supra*.

clear that the *aged* could receive ICF services not only in ICFs but in an "institution for . . . mental diseases." *Id.* § 297 (amending 42 U.S.C. § 1396d(a)(14)). It had been pointed out to Congress that the law first transferring the ICF program to Medicaid could be read as barring even the aged from receiving coverage for "intermediate" services while residing in "public hospitals for mental diseases."²⁵ In response, Congress sought to reaffirm its original intention of allowing the aged full coverage for all services in mental institutions.²⁶

HHS relies on this provision as an indication that Congress did not want to pay for ICF services to the mentally ill under 65. But this argument simply confuses the concept of ICF *services* and the concept of an ICF *facility*. It is clear that Congress did not want to cover persons under 65 living in mental hospitals for any services, be they "intermediate" or anything else. But this hardly suggests that Congress ever declined to cover persons under 65 in ICFs serving a majority of mentally ill patients.

Also in the 1972 Act, Congress added coverage for "in-patient psychiatric hospital services for individuals under 21." Pub. L. No. 92-603, § 299B, 86 Stat. 1460-61 (1972) (adding 42 U.S.C. § 1396d(a)(16), (h)). This new program, which applies only to those hospitals accredited by the Joint Commission on the Accreditation of Hospitals,²⁷ originated in Senate amendments to the House bill. The Senate amendments also included a proposal (ultimately rejected by the House) for "demonstra-

²⁵ See Social Security Amendments of 1971: Hearings on H.R. 1 Before the Senate Comm. on Finance, 92nd Cong., 1st & 2d Sess., Pt. 2, 932 (1972) (Kenneth Gaver, M.D., representing NASMHPD).

²⁶ In the colloquy following the suggestion that an ambiguity existed, Chairman Long confirmed that this had been the original intention. *Id.*

²⁷ The Commission is a private body that accredits hospitals, including state mental hospitals, to determine whether they are providing quality care and treatment.

tion projects" testing the desirability of covering persons between the ages of 21 and 65—again to be limited to accredited psychiatric hospitals. H.R. 1, 92nd Cong., 2d Sess. § 299B(d) (1972).

These provisions create a problem for those who would assert that the IMD exclusion bars coverage for all under-age-65 residents of ICFs serving primarily the mentally ill. Such a theory requires one to believe that Congress intended to deny patients aged 21 and under the opportunity to receive coverage in "specialized" ICFs even as it covered them for the first time in accredited psychiatric hospitals. In addition, it requires a similar assumption about the coverage that would have been afforded to patients aged 22-64 in the Senate's proposed demonstration projects. In view of Congress's repeated assertions about the benefits of alternative, less "intensive" facilities for the chronically ill, these assumptions are simply untenable.

E. The Second Circuit's Analysis of Legislative History.

The Second Circuit, of course, ruled that ICFs could be excluded as IMDs. But its analysis of the legislative history contains two fundamental flaws. First, it wholly fails to take into account the basic policy determination to cover the mentally ill of all ages made by Congress when it created the ICF program. Then it relies on references to various hearings that do not even come close to supporting its position.

The heart of the Second Circuit's opinion is the following assertion:

Both statutory language and the legislative history demonstrate that, with certain exceptions not at issue, Congress has explicitly declined to permit the use of Medicaid funds for custodial care and treatment of the mentally ill under age 65, *regardless of the type of facility in which that care and treatment are provided.*

731 F.2d at 1056 (emphasis added). This conclusion, to be sure, does have the virtue of clarity. But even respondents have not argued that it comes close to an accurate summary of what Congress actually intended.

Put simply, the court's analysis ignores two key facts. First, as we have discussed, there was no age criterion in the ICF program as originally passed. In other words, using the Second Circuit's language, the Congress in 1967 *did* decide to provide "custodial" care to the mentally ill, irrespective of age. Just as importantly, the ICF program as presently incorporated into Medicaid still provides coverage irrespective of age. Even the Court of Appeals was forced to acknowledge that mentally ill persons under 65 in ICFs *are* eligible for aid under present law, as long as the ICF serves enough of the physically disabled to avoid being labelled an IMD by respondents. 731 F.2d at 1056. But the Court inexplicably ignored the significance of this fact, concluding incorrectly that Congress was unwilling to cover custodial care for the mentally ill under age 65 in *any* facility.

Starting from this fundamental misconception, the Second Circuit sought to buttress its position with an incomprehensible analysis of the statutory language,²⁸ and several citations to legislative history that are dem-

²⁸ The court seems to have found some evidence of congressional intent in the fact that Congress in 1971 authorized Medicaid coverage for a special category of facilities—public institutions providing intermediate care to the mentally retarded, commonly called "ICF/MRs." 731 F.2d at 1057. See note 23 *supra*. We fail to see how this demonstrates any intent to restrict the existing coverage for the mentally ill in "ICFs," as that term was originally understood. In fact, the new coverage for ICF/MRs was, as we have noted, intended to bring in large state institutions that had previously been considered IMDs. If Congress had only been concerned with providing coverage for the mentally retarded in true ICFs, it would not have been necessary for it to create the wholly new concept of an institution called an ICF/MR. Instead, Congress

onstrably inapt. Most prominent among the latter references is a discussion of the Senate Report accompanying the original Medicaid bill. *Id.* at 1058 (citing S. Rep. No. 404, 89th Cong., 1st Sess. 145 (1965)). The section cited refers to the fact that the 1965 amendments removed the IMD exclusion for the aged eligible for Medicaid and income assistance. Report at 144-45. It also refers to the new requirement that state plans for assisting the aged in IMDs include provisions facilitating deinstitutionalization to "alternative" facilities where possible. Somehow, the Second Circuit derives from this discussion evidence that such alternative facilities were themselves considered IMDs. 731 F.2d at 1058. But there is no indication whatever in the language of the report that Congress was making any such assumption. In any event, as we previously explained, no ICF was covered in 1965, even if it served people over 65.

Equally specious is the Second Circuit's analysis of the 1972 hearing testimony of representatives of *amicus* NASMHPD. *Id.* at 1059 (citing Social Security Amendments of 1971: Hearings on H.R. 1 before the Senate Commission on Finance, 92nd Cong., 1st and 2d Sess. 924-29 (1972)). These officials, who testified three weeks after the transfer of the ICF program to Medicaid, were discussing the benefits that could be gained by covering patients of all ages in "mental hospitals." Hearings at 928. They pointed out that the Medicaid coverage of the aged in state hospitals had, since 1965, "transformed these hospitals from . . . human warehouses . . . into active treatment centers." *Id.* at 925. As evidence of this treatment success, they pointed to the increased deinstitutionalization of the aged into community facilities, including ICFs. *Id.* at 928. On the basis of this success, they argued for the "equity" of extending the same bene-

could have remained comfortable with the ICF program itself, which covers both the mentally ill and the mentally retarded in true ICFs.

fits to other patients in "public institutions" and "private mental hospitals." *Id.* at 929.

Contrary to the Second Circuit's view, this testimony hardly indicates that these officials took a position on existing Medicaid coverage for ICF (as distinct from IMD) residents. 731 F.2d at 1059. They made no comments whatever on the issue. Nor can any position be inferred. In fact, the history presented entirely involved the period prior to the transfer of ICF coverage to Medicaid. Since there were no age categories in the earlier Title XI program, the witnesses' discussion of the deinstitutionalization achieved for the aged cannot have been intended as an argument for extending ICF coverage. That coverage had clearly been equal during the relevant period. The problem at issue was the unequal treatment of patients over and under 65 in psychiatric hospitals.

The flaws in two other references to legislative history are discussed in the margin.²⁹ Ultimately, it must be

²⁹ The court refers to the 1967 testimony of Dr. Robert Gibson representing *amicus* the American Psychiatric Ass'n and the National Association of Private Psychiatric Hospitals. 731 F.2d at 1058 (citing Social Security Amendments of 1967: Hearings on H.R. 12080 Before the Senate Comm. on Finance, Pt. 3, 90th Cong., 1st Sess. 1741 (1967)). Dr. Gibson was seeking an expansion of Medicaid funding for psychiatric inpatient care for persons under 65. He contrasted the existing psychiatric coverage for persons under 65—in general hospitals only—with coverage for the aged in any facility, including a psychiatric hospital and a community mental health center. *Id.* This testimony is irrelevant to the present issue. To begin with, it involved only psychiatric hospitalization, and the well-understood lines drawn in that arena by the IMD exclusion. Indeed, there was no ICF coverage for anyone when he was testifying, and none in Medicaid until 1971. Thus the comparisons drawn cannot have included intermediate care.

The Second Circuit also refers to 1970 comments by Harry Schnibbe (representing *amicus* NASMHPD) concerning a House bill that was never enacted. 731 F.2d at 1058-59 (citing Social Security Amendments of 1970: Hearings on H.R. 17550 Before the Senate Comm. on Finance, 91st Cong., 2d Sess. 501-02 (1970)). As we have already discussed, that bill contained a provision that would have clarified the fact that the original ICF program did not cover public mental

concluded that the Second Circuit offered no substantial evidence supporting its interpretation. This might not matter if the legislative history were truly silent, or if the outcome reflected a coherent policy position. But we have already shown that the legislative record is far from silent. And the argument for reversal becomes even more compelling when one examines the policies reflected in HHS's rule.

II. HHS'S POSITION UNDERMINES ANY SENSIBLE POLICY THAT CONGRESS INTENDED BY INCLUDING THE MENTALLY ILL IN THE ICF PROGRAM.

In assessing the appropriateness of the IMD exclusion as interpreted by HHS, it is important to understand fully the peculiarities of the line that the Department has drawn. Conceding, as it must, that Medicaid does cover mentally ill patients of all ages in ICFs, HHS argues that this coverage should stop for all patients under age 65 when a given ICF becomes an "IMD." According to the Department Guidelines,³⁰ this can occur when a facility serves too many mental patients overall,³¹ serves too many people under age 65 who are mentally ill,³² serves too many transferees from state mental institutions,³³ or hires too many staff members who have "specialized psy-

hospitals or institutions for the retarded. The witness opposed this on the ground that it was desirable to encourage intermediate-level care in such facilities. *Id.* at 502. Strangely enough, the Second Circuit drew from this testimony evidence that the IMD exclusion covers facilities *other* than mental institutions—i.e., ICFs.

³⁰ The current Guidelines, promulgated only as part of the *State Medicaid Manual*, are set out in the *Medicare and Medicaid Guide (CCH)* ¶ 14,601, at 6295 [hereinafter "Current Department Guidelines"]. Respondents in this case applied an older set of Guidelines that went so far as to penalize an ICF for being within 25 miles of a state mental hospital. Pet. App. at 28d-29d.

³¹ Current Department Guidelines #6, 8.

³² Current Department Guidelines #9.

³³ Current Department Guidelines #7.

chiatric training."³⁴ In other words, the Department's position is that an ICF can serve the mentally ill but its care must be strictly limited, quantitatively and qualitatively.

Singularly missing from HHS's position is any explanation as to why Congress would adopt such a position. Application of the IMD rule to mental hospitals leads to the exclusion of a homogeneous class of persons: the under-65 patients in such facilities, all of whom, by definition, are mentally ill. While amici may not agree that such an exclusion is desirable, at least it was based on an intelligible set of policy judgments about mental hospitals, as we have explained above.

But when the IMD rule is extended to ICFs, as HHS would do, the situation is quite different. The rule not only produces unequal treatment of identical mentally ill persons receiving the same level of care in comparable ICFs, it also extends this irrational discrimination to the physically disabled as well. For example, if an ICF had 60 percent mentally ill and 40 percent physically ill (and the staff to serve these people properly) it would probably be classified as an IMD under the Department's guidelines and *all* of its residents under age 65 would be ineligible for Medicaid. If, however, the mix of physical and mental patients in the ICF were reversed (and the staffing changed to reflect the new mix), all residents would then be eligible for Medicaid. Can it really be that a shift of 20 percent of mentally ill patients (or less) was intended to have such a dramatic impact?

Aside from the illogical quality of HHS's position, its likely effect on the course of future events is neither difficult to trace nor heartening to contemplate. First, of course, if the mentally ill are to remain covered under Medicaid, they will have to be dispersed into the hundreds of ICF-level nursing homes primarily serving the elderly and persons with physical disabilities. While such facilities may well be appropriate for some chronically

³⁴ Current Department Guidelines #4.

mentally ill patients, there can be little doubt that concentration of the mentally ill in certain ICFs is often preferable from a clinical point of view and would result in economies of scale that will allow staffing better designed to meet the needs of this population.

Second, even those ICFs that have fewer than 50% mentally ill residents will be concerned about the danger of losing Medicaid coverage for all their patients under age 65 in the event they should be deemed an IMD under the regulatory criteria. The likely result is an access problem for mentally ill patients needing ICF care. Under the HHS criteria, ICFs will have a clear incentive to exclude mentally ill patients. And this problem will become especially acute when a facility's population of mentally ill persons approaches the "critical mass" that may be needed to make possible the psychiatrically oriented programs of care that many patients require.³⁵

These are not idle concerns. Numerous experts have already pointed to the undesirability of attempting to care for at least certain categories of mentally ill people in nursing homes geared to the needs of the elderly. First, there are problems caused by the mixture of very different patient populations. A study by the Senate Special Committee on Aging concluded that "the effect of mixing the physically infirm patients with mentally impaired is often deleterious."³⁶ And HHS's own proposed plan for meeting the needs of the chronically men-

³⁵ Exclusion and inadequate care would, under the Department's rule, be imposed on Medicaid-eligible persons solely by virtue of the fact that their disability is caused by mental, rather than physical illness. It seems most unlikely that Congress, having chosen to provide ICF services to the mentally ill, intended to do so on terms that would predictably lead to discrimination against them. Cf. *Schweiker v. Wilson*, 450 U.S. 221 (1981); *Minnesota v. Heckler*, 718 F.2d 852, 865 (8th Cir. 1983).

³⁶ Staff of the Special Senate Comm. on Aging, 94th Cong., 2d Sess., *The Role of Nursing Homes in Caring for Discharged Mental Patients at XI* (Comm. Print. 1976) [hereinafter "Senate Study"].

tally ill agreed, stating in 1980 that "the need for a quiet orderly environment for extremely ill persons may not be compatible with the needs of an ambulatory, active chronically mentally ill person."³⁷

The Senate study also concluded that non-specialized nursing homes are too often "poorly equipped" to meet the needs of certain mentally ill persons. "There are generally no psychiatric services available; no plans to rehabilitate patients; there are not sufficient numbers of trained staff people to care for their needs . . ." ³⁸ And here again HHS's plan agreed, stating that the "range of the treatment and rehabilitative programs" needed by some mentally ill patients "are generally not available" in regular nursing homes. Significantly, the plan then linked this problem directly to "legislative exclusions, or regulatory interpretation of legislation," including HHS's reading of the IMD exclusion, that have created "disincentives to appropriate service."³⁹

It should also be emphasized that the position we are taking does not mean that a state can simply label a facility an ICF and thereby get Medicaid coverage for its residents. There are appropriate limitations, intended by Congress, that the Department may still employ. First, hospitals and ICFs provide different levels of care. The nature and amount of medical services, including specifically active psychiatric treatment, are significantly different in the two settings. The guidelines established

³⁷ *Toward a National Plan for the Chronically Mentally Ill* at 2-31 (Report to the Sec'y of H.H.S. by the Steering Committee on the Chronically Mentally Ill, Dec. 1980) [hereinafter "*Toward a National Plan*"].

³⁸ Senate Study, *supra*, at XI.

³⁹ *Toward a National Plan*, *supra*, at 2-31. See also Comptroller General of the U.S., *Returning the Mentally Disabled to the Community: Government Needs to Do More* 90-91 (GAO Report 1977) (officials at the National Institute of Mental Health believe that application of the IMD requirement to ICFs and SNFs "hinders deinstitutionalization" and "hinders the development of appropriate programs" for the mentally ill).

by the Joint Commission on the Accreditation of Hospitals, an accrediting body formally recognized by Congress in the Medicaid statute, *e.g.*, 42 U.S.C. § 1396d(h)(1)(A), carefully distinguish between hospital-based care and long-term care such as that provided by ICFs to the mentally ill.⁴⁰ Competent professionals available to HHS can readily apply these criteria.

In addition, even when a facility is properly classified as an ICF, that does not mean that *all* of its residents are Medicaid-eligible. The Department is still authorized to determine that a particular resident is not appropriately placed in such a facility because, for example, he requires hospital-based care in an IMD.⁴¹ These kinds of determinations, while requiring HHS to take somewhat greater care perhaps, far better satisfy congressional intent than the improper criteria that the Department now uses.

III. HHS'S RULE WOULD IMPOSE INTOLERABLE BURDENS ON STATE EFFORTS TO MEET THE NEEDS OF THE CHRONICALLY MENTALLY ILL.

It is also important, in our view, for the Court to understand the full impact that the decision in this case will have. The nation's mental health system has changed greatly since the 1960's, as the primary locus of long-term care for the chronically mentally ill has shifted from state hospitals to private facilities in the community. Understandably, this movement has placed significant pressures on community-based facilities and services that are attempting to meet the needs of the many thousands of people who have left state institutions. In the present context, it is simply indefensible for HHS to

⁴⁰ Compare Consolidated Standards Manual for Child, Adolescent and Adult Psychiatric, Alcoholism and Drug Abuse Facilities (JCAH 1981) with Accreditation Manual for Long-Term Care Facilities (JCAH 1980).

⁴¹ See 42 U.S.C. § 1396a(a)(31) (state Medicaid plan must provide for periodic review and on site inspections geared to assessment of appropriateness of each patient's placement in an ICF).

be adopting a regulatory approach that flies in the face of this massive effort—at least without far clearer indicia of legislative intent than it is able to muster here.

The statistics documenting this process are dramatic. Between 1955 and 1980, the resident census in state and county mental hospitals shrank from 559,000 to 138,000.⁴² This reduction has resulted primarily from major shortening of the average patient's length of stay in these facilities.⁴³ The underlying causes have included the introduction of new psychoactive medications, congressional mandates, reforms of civil commitment laws, and a general recognition of the inadequacy of traditional state institutions as places of long-term "asylum".

With most of the chronically mentally ill now living outside of the old institutions, the states have been making major efforts to meet the needs of this population for alternative residential opportunities. These efforts generally involve various "extended care facilities"—"board and care" facilities for the less disabled and nursing homes (ICFs and SNFs) for those requiring greater support and more intensive care.⁴⁴ Nursing homes alone have been called the "single largest providers of services to chronically mentally ill persons in the country."⁴⁵ And, while many of the mentally ill in nursing homes are elderly persons suffering from senility, there are also

⁴² Goldman *et al.*, *Deinstitutionalization: The Data Demythologized*, 34 *Hosp. & Community Psych.* 129, 131 (1983).

⁴³ *Id.*

⁴⁴ See Kohen & Paul, *Current Trends and Recommended Changes in Extended Care Placement of Mental Patients: The Illinois System as a Case in Point*, 2 *Schizophrenia Bull.* 575, 576 (1976); Comptroller General of the U.S., *Returning the Mentally Disabled to the Community: Government Needs to Do More* 10 (GAO Report 1977).

⁴⁵ *Toward a National Plan*, *supra*, at 2-32.

thousands of younger persons in such facilities afflicted with schizophrenia and other disorders.⁴⁶

Because of the heavy fiscal burden involved, the process of providing community-based alternatives for the chronically mentally ill is far from complete at the present time. There is a shortage of residential options, and many of the existing facilities remain sub-standard.⁴⁷ And where sufficient alternatives do not yet exist, one common outcome is the homelessness of many who, in times past, would have been served by state mental hospitals.⁴⁸

In view of the shift toward nursing home care for the chronically mentally ill, and the fiscal crisis now confronting states in this area, a decision upholding HHS's broad IMD exclusion would cause serious problems for states that have been providing Medicaid funds to ICFs that care largely for the mentally ill.⁴⁹ First, those states would face the prospect of disallowances of previous federal Medicaid payments—causing still further budgetary problems. In other words, there would be a financial penalty imposed on those states, and only those states that, in good faith, have been providing quality care in psychiatrically oriented ICFs.

⁴⁶ Goldman, *Long-Term Care for the Chronically Mentally Ill* 18 (Urban Inst. report 1983).

⁴⁷ See, e.g., Senate Study, *supra*, at 743-52; Comptroller General of the U.S., *Returning the Mentally Disabled to the Community: Government Needs to Do More* 126 (GAO Report 1977).

⁴⁸ See Talbott & Lamb, "Summary and Recommendations," in *The Homeless Mentally Ill* 2 (Amer. Psychiatric Ass'n Task Force Report, H.R. Lamb ed., 1984) ("It is now apparent that a substantial portion of the homeless are chronically and severely mentally ill men and women who in years past would have been long-term residents of state hospitals.")

⁴⁹ A GAO study in 1977 found a substantial number of ICFs in the Medicaid program which emphasized care for the mentally disabled. Comptroller General of the U.S., *Returning the Mentally Disabled to the Community: Government Needs to Do More* 90-91, 178, 187 (GAO Report 1977).

Those same states (as well as others) would also face a difficult choice for the future. If they wanted to secure Medicaid funding of intermediate care for their mentally ill citizens, they would have only one option—dispersing them among the elderly in non-specialized nursing homes. If they rejected or were unable to achieve this sometimes less desirable option, and thus had to fund the care themselves, there would be strong financial pressures favoring a return to the public institutions instead of the private ICF. After all, from the state's point of view, the marginal cost of one more institutional patient is certainly less than the cost of care in private ICFs, which are invariably reimbursed on a per-patient basis.

The consequences that will inevitably flow from this unfortunate and, we believe, unintended set of options would be grave. One of the important overall effects of the ICF program, as designed by Congress, is that many former mental hospital patients are now being adequately cared for in more appropriate ICFs. These are people who, it has been shown, do not require the intensive care provided during psychiatric hospitalization. At the same time, by moving such people out of state hospitals, many states have been able to provide better care for those who properly remain in such hospitals. The current situation, while far from perfect, reflects considerable progress in the past twenty years. The position taken by HHS in this litigation would not only halt this progress, it would almost certainly begin to undo it. State hospitals would once again become a repository for those mentally ill citizens who have no place else to go. This result, in turn, would lead to improper hospital placement for many and less good hospital care for those who need it. Nothing adduced by HHS or the Court of Appeals indicates that Congress intended such perverse results.

CONCLUSION

For these reasons, the judgment below should be reversed.

Respectfully submitted,

PAUL LITWAK
44 Holland Avenue
Albany, New York 12229
R. EMMETT POUNDSTONE, III
P.O. Box 3710
Montgomery, Alabama 26193
*Of counsel for amicus the
National Ass'n of State Mental
Health Program Directors*

January 2, 1985

JOEL I. KLEIN
PAUL M. SMITH
ONEK, KLEIN & FARE.
2550 M Street, N.W.
Washington, D.C. 20037
(202) 775-0184

Counsel for Amici Curiae

JAN 8 1985

ALEXANDER L. STEVENS,
CLERK

7

No. 83-2136

IN THE
Supreme Court of the United States
OCTOBER TERM, 1984

STATE OF CONNECTICUT,
DEPARTMENT OF INCOME MAINTENANCE,
Petitioner,

v.

MARGARET M. HECKLER, SECRETARY,
AND THE UNITED STATES DEPARTMENT
OF HEALTH AND HUMAN SERVICES,
Respondents.

On Writ Of Certiorari To
The United States Court Of Appeals
For The Second Circuit

BRIEF FOR PETITIONER

JOSEPH I. LIEBERMAN
Attorney General
30 Trinity Street
Hartford, Connecticut 06106

DONALD M. LONGLEY
Assistant Attorney General
90 Brainard Road
Hartford, Connecticut 06114

CHARLES A. MILLER*
MICHAEL A ROTH
ROBIN J. ARMBRUSTER
COVINGTON & BUELLING
1201 Pennsylvania Ave., N.W.
P.O. Box 7566
Washington, D.C. 20044
(202) 662-6000

*Attorneys for Petitioner State
of Connecticut, Department of
Income Maintenance*

*Counsel of Record

January 1985

QUESTION PRESENTED

The Medicaid law, enacted in 1965 to provide federal financial support for medical assistance provided by states to needy people, does not cover services to patients under age 65 in an "institution for mental diseases" ("IMD"). A later amendment extended coverage to "intermediate care facilities" ("ICFs"), defined as institutions that serve people, without age limitation, requiring residential care for their mental or physical condition, but whose illness is not so severe as to require the greater degree of care furnished by a hospital or a skilled nursing facility. The question is whether the "IMD" limitation on coverage applies only to mental hospitals, or should be extended to ICFs that serve people requiring ICF-type care for their mental conditions.

TABLE OF CONTENTS

	<u>Page</u>
OPINIONS BELOW	2
JURISDICTION	3
STATUTORY PROVISIONS INVOLVED	3
STATEMENT	4
A. Pertinent Statutory and Regulatory Framework	5
B. The Current Dispute	9
SUMMARY OF ARGUMENT	15
ARGUMENT	22
I. A BRIEF RESUME OF THE EVOLUTION OF FEDERAL POLICY ON THE PROBLEMS OF MENTAL ILLNESS	24
A. Development and Nature of State Mental Hospitals	24
B. Establishing the Basis For Federal Policy	27
C. Origins of the IMD Provision in the Social Security Act	33
D. Expansion of Support for Care of the Mentally Ill Under Medicaid -- The Long Amendment	39

	<u>Page</u>
E. Extension of the Social Security Act To Cover Intermediate Care Facilities	46
II. MIDDLETOWN HAVEN QUALIFIED AS A MEDICAID PROVIDER UNDER THE STATUTE	49
A. Medicaid Covers ICFs Treating People Whose Mental Condition Creates Their Need For Care	49
B. The IMD Provisions of the Statute Do Not on Their Face Preclude Coverage For ICFs Specializing in Care of Residents With Mental Conditions	51
C. Legislative and Administrative History Confirms That the IMD Exclusion Applies Only To Mental Hospitals	60
1. Evolution of the IMD Exception	60
2. Congressional Acknowledgment of the Limited Scope of the IMD Exception	68

	<u>Page</u>
3. Administrative Recognition of the Limited Scope of the IMD Exception	72
4. The Courts' Understanding of the IMD Exclusion	79
5. The Faulty Analysis of the Court of Appeals	82
III. THE CHALLENGED DISALLOWANCE ACTION UNDERMINES THE FEDERALISM CONCEPT ON WHICH THE PUBLIC ASSISTANCE PROGRAMS ARE BASED	93
A. The Disallowance Was Based on New and Uncertain Policies Not Implemented Until After the Federal Funds Were Received and Spent	93
B. After-The-Fact Disallowances Are Impermissible Under the Public Assistance Titles of the Social Security Act	102
IV. DEFERENCE TO THE DHHS INTERPRETATION OF THE IMD EXCEPTION IS NOT JUSTIFIED	108

Page

A.	The Department's Position Does Not Merit Deference Under the Applicable Precedents . . .	108
B.	The Department's Interpretation Is Premised on Policy Grounds That Are In Conflict With the Policy Adopted By Congress	112
CONCLUSION		118
APPENDIX A --	Full Text of Statu- tory Provisions Involved	1a
APPENDIX B --	Excerpts from Senate Report No. 404, Part I, 89th Cong., 1st Sess. (1965)	1b
APPENDIX C --	Excerpts from DHEW, Social Security Administration, Office of Research and Statistics: Financing Mental Health Care Under Medicare and Medicaid (Research Report No. 37) (1971)	1c

TABLE OF AUTHORITIES

Page

CASES

<u>Addington v. Texas</u> , 441 U.S. 418 (1979)	23
<u>Batterton v. Francis</u> , 432 U.S. 416 (1977)	111
<u>Bell v. New Jersey</u> , 461 U.S. 773, 76 L.Ed.2d 312 (1983)	94
<u>Bulova Watch Co. v. United States</u> , 365 U.S. 753 (1961)	57
<u>Commonwealth of Kentucky Department of Education v. Secretary of Education</u> , 717 F.2d 943 (6th Cir. 1983), cert. granted, 83 L.Ed.2d 26 (1984)	105
<u>Consumer Product Safety Commission v. GTE Sylvania, Inc.</u> , 447 U.S. 102 (1980)	51
<u>Dandridge v. Williams</u> , 397 U.S. 471 (1970)	22
<u>Doe v. Colautti</u> , 592 F.2d 704 (3d Cir. 1979)	82

	<u>Page</u>
<u>Federal Election Commission</u> <u>v. Democratic Senatorial</u> <u>Campaign Committee, 454</u> U.S. 27 (1981)	109
<u>Harris v. McRae, 448</u> U.S. 297 (1980)	20,22,103
<u>Herweg v. Ray, 455</u> U.S. 265 (1982)	111
<u>Illinois v. United States</u> <u>Department of Health</u> <u>and Human Services, No.</u> <u>82-C-1349 (N.D. Ill.</u> <u>June 30, 1984) (appeal</u> <u>pending)</u>	14
<u>Kantrowitz v. Weinberger,</u> <u>388 F. Supp. 1127, (D.D.C.</u> <u>1974), aff'd, 530 F.2d 1034</u> <u>(D.C. Cir.), cert. denied,</u> <u>429 U.S. 819 (1976)</u>	82
<u>King v. Smith, 392 U.S.</u> <u>309 (1968)</u>	22,73,103
<u>Legion v. Richardson, 354</u> <u>F. Supp. 456 (S.D.N.Y.),</u> <u>aff'd sub nom. Legion v.</u> <u>Weinberger, 414 U.S. 1058</u> <u>(1973)</u>	82
<u>Minnesota v. Heckler,</u> <u>718 F.2d 852 (8th Cir.</u> <u>1983)</u>	13,82, 101,117

	<u>Page</u>
<u>Minnesota v. Schweiker,</u> <u>No. 4-82-155 (D. Minn.</u> <u>August 25, 1982)</u>	13
<u>Morton v. Mancari, 417</u> U.S. 535 (1974)	57
<u>NLRB v. Brown, 380</u> U.S. 278 (1965)	109
<u>O'Connor v. Donaldson, 422</u> U.S. 563 (1975) (Burger, C.J. concurring)	27
<u>Pennhurst State School v.</u> <u>Halderman, 451 U.S. 1</u> <u>(1981)</u>	20,104, 105,108
<u>Rosado v. Wyman, 397</u> U.S. 397 (1970)	22
<u>SEC v. Sloan, 436 U.S.</u> <u>103 (1978)</u>	109
<u>Saxbe v. Bustos, 419</u> U.S. 65 (1974)	110
<u>Schweiker v. Gray Panthers,</u> <u>453 U.S. 34 (1981)</u>	54,111
<u>Schweiker v. Wilson,</u> <u>450 U.S. 221 (1981)</u>	18,80,81, 82

	<u>Page</u>
<u>Security Industry</u>	
<u>Association v. Board of</u>	
<u>Governors, 82 L.Ed.2d</u>	
107 (1984)	21,109, 111,116
 <u>United States v. Cartwright,</u>	
411 U.S. 546 (1973)	108
 <u>Volkswagenwerk Aktiengesell-</u>	
<u>schaft v. FMC, 390 U.S.</u>	
261 (1968)	109
 <u>STATUTES</u>	
<u>Mental Health Study Act</u>	
of 1955, Pub. L. No.	
84-182, 69 Stat. 381	29
 <u>Mental Retardation</u>	
Facilities and Community	
Mental Health Centers	
Construction Act of	
1963, Pub. L. No. 88-164,	
77 Stat. 282	32
 <u>National Mental Health Act</u>	
of 1946, Pub. L. No.	
79-487, 60 Stat. 421	28,36
 <u>Omnibus Budget Reconcilia-</u>	
<u>tion Act of 1980, Pub.</u>	
L. No. 96-499, 94 Stat.	
2599	53
 <u>Rehabilitation Act of 1973,</u>	
29 U.S.C. § 794	117

	<u>Page</u>
<u>Social Security Act of</u>	
1935, 49 Stat. 620	
§ 3	34
§ 1003	34
 <u>Social Security Act Amend-</u>	
<u>ments of 1950, Pub. L.</u>	
No. 81-734, 64 Stat. 549	
§ 301(b)	36
§ 303	34-35
§ 343	34-35
§ 351	34-35
 <u>Social Security Act Amend-</u>	
<u>ments of 1960, Pub. L.</u>	
No. 86-778, 74 Stat. 924	
§ 601	37,38,62, 66
 <u>Social Security Act Amend-</u>	
<u>ments of 1967, Pub. L.</u>	
No. 90-248, 81 Stat. 821	
§ 250	7,47
 <u>Social Security Act Amend-</u>	
<u>ments of 1971, Pub. L.</u>	
No. 92-233, 85 Stat. 802	
§ 4	48
 <u>Social Security Act Amend-</u>	
<u>ments of 1972, Pub. L.</u>	
No. 92-603, 86 Stat. 1460	
§ 299B	48
 <u>Social Security Act, as</u>	
amended, 42 U.S.C.	
§ 301, <u>et seq.</u>	5
§ 603	107
§ 604	107

	<u>Page</u>
§ 1396a(a)(10)	67-68, 117
§ 1396a(a)(20) and (21)	3, 6, 15, 41, 44, 45, 52, 65, 101, 114
§ 1396a(a)(26) and (33)	115
§ 1396b(d)	107
§ 1396c	107
§ 1396d(a)	3, 6, 7, 52, 56, 66, 71, 78
§ 1396d(c)	3, 7, 16, 48, 49, 53, 58
5 U.S.C. § 704 (1976)	14
28 U.S.C. § 1254(1)	3
28 U.S.C. § 1331 (1982)	14
Senate Resolution No. 141, 80th Cong., 1st Sess. (1947)	35

LEGISLATIVE MATERIALS

Reports:

H.R. Rep. No. 1300, 81st Cong., 1st Sess. (1949) . . .	37
H.R. Rep. No. 1799, 86th Cong., 2d Sess. (1960) . . .	37

	<u>Page</u>
H.R. Rep. No. 2165, 86th Cong., 2d Sess. (1960) . . .	38
H.R. Rep. No. 694, 88th Cong., 1st Sess. (1963) . . .	32, 33
H.R. Rep. No. 213, 89th Cong., 1st Sess. (1965) . . .	45, 64, 114
H.R. Rep. No. 1096, 91st Cong., 2d Sess. (1970) . . .	59
H.R. Rep. No. 1605, 92d Cong., 2d Sess. (1972) . . .	70
S. Rep. No. 1353, 79th Cong., 2d Sess. (1946) . . .	28
S. Rep. No. 1669, 81st Cong., 2d Sess. (1950) . . .	36, 37
S. Rep. No. 870, 84th Cong., 1st Sess. (1955) . . .	30
S. Rep. No. 1856, 86th Cong., 2d Sess. (1960) . . .	37
S. Rep. No. 1513, 88th Cong., 2d Sess. (1964) . . .	63
S. Rep. No. 404, Pt. I, 89th Cong., 1st Sess. (1965) . . .	6, 34, 42, 45, 64, 68, 114
S. Rep. No. 744, 90th Cong., 1st Sess. (1967) . . .	47

	<u>Page</u>
S. Rep. No. 1431, 91st Cong., 2d Sess. (1970) . . .	60
S. Rep. No. 1230, 92d Cong., 2d Sess. (1972) . . .	70, 71
 <u>Hearings:</u>	
Hearings on H.R. 11865 Before the Senate Committee on Finance, 88th Cong., 2d Sess. (1964)	72
Hearings on Social Security Amendments of 1967 Before the Senate Committee on Finance, Part 1, 90th Cong., 1st Sess. (1967). . .	43
Social Security Amendments of 1967: Hearings on H.R. 5710, Before the House Committee on Ways and Means, 90th Cong., 1st Sess. (1967)	87
Social Security Amendments of 1967: Hearings on H.R. 12080 Before the Senate Committee on Finance, 90th Cong., 1st Sess.	87
Hearings on Social Security Amendments of 1970 Before the Senate Committee on Finance, 91st Cong., 2d Sess. (1970)	59, 78-79, 88, 89

	<u>Page</u>
Hearings on Social Security Amendments of 1971 Before the Senate Committee on Finance, 92d Cong., 1st and 2d Sess. (1972)	32, 90, 91, 116
 <u>Debates:</u>	
106 Cong. Rec. 16001-16006 (1960)	38
108 Cong. Rec. 7849-50 (1962)	32
108 Cong. Rec. 14628 (1962)	40
108 Cong. Rec. 19130 (1962)	40
110 Cong. Rec. 21085 (1964)	63
110 Cong. Rec. 21346-49 (1964)	43, 63
111 Cong. Rec. 15805 (1965)	73
116 Cong. Rec. 43868 (1970)	60
117 Cong. Rec. 44721 (1971)	69

	<u>Page</u>
<u>Documents:</u>	
H.R. Doc. No. 44, 89th Cong., 1st Sess. (1965) . . .	45-46
House Committee on Ways and Means, 89th Cong., 1st Sess., Summary of Major Provisions of Medical Assistance for the Aged Program (Comm. Print 1965)	62
House Committee on Ways and Means, 89th Cong., 1st Sess., Summary of Deci- sions by Committee on Health Insurance, etc. (Comm. Print 1965)	41
Senate Document No. 208, 80th Cong., 2d Sess. (1949)	35,36
<u>Bills:</u>	
H.R. 1, § 299B (92d Cong., 2d Sess)	70
H.R. 17550 (91st Cong., 2d Sess.)	59
<u>DHEW/DHHS ADMINISTRATIVE MATERIALS</u>	
42 C.F.R. §§ 405.1036, 405.1038 (1983)	51

	<u>Page</u>
42 C.F.R. §§ 435.1009, 440.140 (1983)	8,51
42 C.F.R. § 440.150(d) (1983)	53
42 C.F.R. § 440.230(c) (1983)	117
42 C.F.R. §§ 442.303, 442.254, 442.333, 442.346 (1983)	51,53
45 C.F.R. §§ 84.3(j), 84.4(b) (1983)	117
45 C.F.R. § 249.10(b)(14)(iv) (1970)	74
Interim Policy Statement No. 23, 33 Fed. Reg. 12925 (1968), modified 34 Fed. Reg. 9782 (1969), 42 C.F.R. § 234.130 (1970)	77
45 Fed. Reg. 47368, 47372 (July 14, 1980)	101
Handbook of Public Assistance Administration, Supplement D § D-5141.14(d) § D-4620.2	8,74 8,60,74, 98

	<u>Page</u>
Field Staff Information and Instruction Series, FY 76-44, FY 76-96, and FY 76-156	9
DHEW, Social Security Administration, Office of Research and Statistics: Financing Mental Health Care Under Medicare and Medicaid (Research Report No. 37) (1971)	75, 76, 77, 86
The Medicare and Medicaid Data Book, 1981 (DHHS, April 1982)	49
DHHS Press Release, October 10, 1984	106
 <u>MISCELLANEOUS</u>	
S. Brakel & R. Rock, <u>The Mentally Disabled and the Law</u> (rev. ed. 1971)	27
Budget of the United States Government FY 1985, Appendix	106
W. Cohen, <u>The Development of the Social Security Act of 1935: Reflections Some Fifty Years Later</u> , 68 Minn. L. Rev. 379 (1983)	40

	<u>Page</u>
R. Connery, <u>The Politics of Mental Health</u> (1968)	27, 32
Comptroller General Report to the Congress: "Returning the Mentally Disabled to the Community: Government Needs to Do More" (January 7, 1977)	95
K. Davis, <u>The Birth of Social Security</u> , 30 American Heritage 38 (April/May 1979)	40
A. Deutsch, <u>The Mentally Ill in America</u> (2d ed. 1947)	27, 28
Historical Statistics of the United States (1975 ed.)	42
L. Johnson, <u>The Vantage Point</u> (1971)	40
Joint Commission on Mental Illness and Health, <u>Action for Mental Health</u> (1961)	30, 31, 32
VII Messages and Papers of the Presidents (1914 ed.)	25
1 Public Papers of the Presidents: Administra- tion of John F. Kennedy (1961)	32

	<u>Page</u>
R. Rock, <u>Hospitalization and Discharge of the Mentally Ill</u> (1968)	27
D. Rothman, <u>The Discovery of the Asylum</u> (1971)	26,27
Statistical Abstract of the United States, 1982-83	42
H. Truman, <u>Years of Trial and Hope</u> (1956)	40

No. 83-2136

IN THE
SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1984

STATE OF CONNECTICUT,
DEPARTMENT OF INCOME MAINTENANCE,

Petitioner,

v.

MARGARET M. HECKLER, SECRETARY,
AND THE UNITED STATES DEPARTMENT
OF HEALTH AND HUMAN SERVICES,

Respondents.

ON WRIT OF CERTIORARI TO
THE UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

BRIEF FOR PETITIONER

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Second Circuit is reported at 731 F.2d 1052 and appears as Appendix A, pp. 1a-16a in the Appendix to the Petition for Certiorari ("Pet. App."). The opinion of the United States District Court for the District of Connecticut is reported at 557 F. Supp. 1077 and appears as Appendix C, pp. 1c-25c in the Appendix to the Petition for Certiorari. The opinion of the Departmental Grant Appeals Board of the United States Department of Health and Human Services ("Department")¹ is unreported and appears as Appendix D, pp. 1d-6ld in the Appendix to the Petition for Certiorari.

¹ Throughout this Brief, we use the references "Department," "DHHS," or "DHEW" to refer to the Department of Health and Human Services or its predecessor, the Department of Health, Education, and Welfare.

JURISDICTION

The judgment of the Court of Appeals was entered on March 30, 1984. Pet. App. 1b. A Petition for a Writ of Certiorari was filed on June 28, 1984, and granted on October 29, 1984. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

This case involves the following sections of the Social Security Act: section 1905(a), 42 U.S.C. §1396d(a)(1), (4)(A), (14), (15) and (18)(B), which defines "medical assistance;" section 1905(c), 42 U.S.C. §1396d(c), which defines "intermediate care facilities;" and section 1902(a)(20) and (21), 42 U.S.C. §1396a(a)(20) and (21), containing the "Long Amendment" specifying certain requirements of state Medicaid plans. The

full text of these sections is set out in Appendix A to this Brief.

STATEMENT

The question presented -- whether the term "institution for mental diseases" ("IMD"), which is used in defining covered health care services (medical assistance) under the Medicaid program, was meant to cover only mental hospitals or embraces as well alternative facilities and settings for the care and treatment of the mentally ill, including intermediate care facilities ("ICFs") -- has been decided against DHHS by four federal courts, including the Court of Appeals for the Eighth Circuit (Pet. App. E), but was decided in favor of DHHS by the court below. Pet. App. A.

Underlying the legal question raised by this case are two broader issues: (1) whether the nation's poor or near-poor

who suffer from mental disabilities will have access to appropriate settings for care and treatment -- such as ICFs -- under the Medicaid law, and (2) whether federal financial support on which the states relied in developing health and welfare programs can be withdrawn after the fact based on legal interpretations not clearly established at the time the programs were undertaken. The resolution of these issues will have a profound effect on the continued viability of state mental health programs for needy people.

A. Pertinent Statutory and Regulatory Framework

The Medicaid program, established in 1965 by Title XIX of the Social Security Act ("the Act"), 42 U.S.C. §§1396 et seq., makes federal funds available to the states to share in the costs of medical care provided to needy individuals,

to the extent covered by an approved State Plan. Services provided to patients under age 65 in institutions for mental diseases ("IMDs") are excluded from federal financial participation. 42 U.S.C. §1396d(a)(18)(B). Services provided to persons 65 and over in IMDs are covered, but only on the condition that the state undertake programs to develop broader alternatives, including nursing homes, for dealing with the problems of the mentally ill. 42 U.S.C. §1396a(a)(20) and (21); S. Rep. No. 404, Pt. I, 89th Cong., 1st Sess. 145-46 (1965) (hereafter cited as "1965 S. Rep."). The term "institution for mental diseases" has never been defined in the statute; however, the statute does distinguish between IMDs, on the one hand, and alternative care settings, such as nursing facilities, on the other. 42 U.S.C. §1396a(a)(21).

In 1967, Congress first authorized federal assistance for intermediate care facility ("ICF") services as part of the programs of cash assistance for the aged, the blind, and the disabled. Pub. L. No. 90-248, §250, 81 Stat. 821, 920. In 1971, Congress repealed these provisions and brought ICF services under Medicaid. 42 U.S.C. §1396d(a)(14). An ICF was defined as an institution that provides medical assistance to individuals who because of their "mental or physical condition" require health care and services, but whose condition is not so severe as to require the degree of care that a hospital or skilled nursing facility provide. 42 U.S.C. §1396d(c).

Shortly after enactment of the Medicaid law, the Department adopted interpretive regulations that defined an IMD eligible for federal funding with respect

to persons aged 65 and over to mean a psychiatric hospital that met prescribed standards. No other category of residential facility was referred to. Handbook of Public Assistance Administration, Supplement D (hereafter cited as "Handbook"), §D-5141.14(d). The Handbook also restated the statutory bar to coverage of any person under 65 who

"is a patient in an institution for ... mental diseases; i.e., an institution whose overall character is that of a facility established and maintained primarily for the care and treatment of individuals with ... mental diseases (whether or not it is licensed)." Handbook, §D-4620.2.

Despite codification and periodic reorganization of the regulations, the substance of these provisions has not changed materially since their first adoption.²

² The present provisions appear in 42 C.F.R. §§435.1009 and 440.140 (1983).

The issue of extending the IMD exception to nursing homes (skilled nursing facilities and intermediate care facilities) first surfaced in a series of internal memoranda from the Central Office staff to regional officials of DHEW in 1975 and 1976.³ After a delay of several years, the Department dispatched audit teams to investigate a number of states to determine whether certain nursing facilities that had been participating in the Medicaid program should be classified as IMDs.

B. The Current Dispute

Since October 1974, Connecticut has provided for coverage of ICF services in its Medicaid Plan. Middletown Haven Rest Home, a 180-bed ICF, began operating as a

³ Field Staff Information and Instruction Series, FY 76-44, FY 76-97, and FY 76-156. Joint Appendix ("J.A.") 1d-11d.

duly certified Medicaid provider in 1977.⁴ From 1977 to 1980, Connecticut received federal funds under the Medicaid program for services provided to eligible residents of Middletown Haven. Pet. App. 4a. The residents of Middletown Haven suffered from a variety of problems, both physical and mental. The facility was equipped to care for residents with mental conditions, although it did not admit patients with acute mental disorders. J.A. 43a. Middletown Haven residents were admitted from a variety of sources,

⁴ Connecticut's ICFs are administered by the Department of Income Maintenance. Connecticut also has four state-run mental hospitals and eight accredited private psychiatric hospitals whose function is the care and treatment of mental illness. These institutions, which are concededly IMDs, are under the jurisdiction of the Connecticut Department of Mental Health and do not receive Medicaid funds for services provided to individuals under age 65. J.A. 2b.

including three state mental hospitals. J.A. 17a.⁵

Federal officials began their investigation of Connecticut's nursing homes in May 1979. In December 1979, an audit was conducted of patient records at Middletown Haven Rest Home. A report issued in May 1980 found that most of the residents at Middletown Haven had mental diagnoses of some sort, and concluded that Middletown Haven should be classified as an IMD. J.A. 2a-25a.⁵ Acting on that report, the Department issued a notice of disallowance to Connecticut in September 1980, in the amount of \$1,645,655, representing all of the federal funds paid to the state for the care of residents at Middletown Haven for the period

⁵ Since the disallowance action under review, Connecticut has not sought federal Medicaid funds for care provided at Middletown Haven.

January 1, 1977, through September 30, 1979. J.A. 1e-6e.⁶

The disallowance was not predicated in any way on the quality of services provided to residents at Middletown Haven. To the contrary, DHHS officials responsible for the audit rated Middletown Haven highly and described it as an "excellent facility" and an "ideal ICF." J.A. 11c, 19c.

Connecticut's request for administrative review of the disallowance was consolidated with similar requests of

⁶ Classification of a facility as an IMD has the effect of precluding financial support for the care of any resident under age 65, whether or not the particular resident suffers from a mental disability. The disallowance in this case applied to all residents of Middletown Haven, although not all were found to have a mental diagnosis. J.A. 17a. Because the Connecticut Medicaid Plan did not opt for coverage of ICF services provided in an IMD, the disallowance was also applied to funds used to support services to residents of Middletown Haven aged 65 and older. J.A. 24a.

Illinois, Minnesota and California by the Departmental Grant Appeals Board ("Board"), a body within DHHS established by the Secretary to resolve disallowance disputes. The Board upheld the disallowances against all four states. Pet., App. D.⁷ The Board's decision was appealed separately by each of the affected states. Minnesota prevailed in the District Court⁸ and the Eighth Circuit Court of Appeals.⁹ Pet., App. E. Illinois

⁷ The disallowance amounts against the other states were \$4,261,162 for Illinois, \$2,329,401 for California, and \$896,159 for Minnesota. Pet. App. 49d, 53d, 61d. Since these initial cases, the Department has asserted disallowances against other states on the same ground, and if its position is sustained here it can be expected to assert disallowances against these and other states with respect to services previously furnished by providers other than those covered by the initial disallowances.

⁸ Minnesota v. Schweiker, No. 4-82-155 (D. Minn. August 25, 1982).

⁹ Minnesota v. Heckler, 718 F.2d 852 (8th Cir. 1983).

prevailed in the District Court.¹⁰ Pet., App. F.¹¹

In this case the District Court granted summary judgment to Connecticut, holding that the different level of care provided to patients in an ICF such as Middletown Haven, as opposed to the level of care expected in a mental hospital, precluded classification of Middletown Haven as an IMD.¹ Pet., App. C.¹² The Second Circuit Court reversed, based upon its conclusion that the term "institution for mental diseases" in the Medicaid

¹⁰ Illinois v. United States Department of Health and Human Services, No. 82-C-1349 (N.D. Ill. June 30, 1984) (appeal pending).

¹¹ No decision has yet been rendered in the district court suit brought by California to challenge its disallowance.

¹² Jurisdiction to review the disallowance action lay in the District Court under 28 U.S.C. §1331 (1982), pursuant to a cause of action conferred by 5 U.S.C. §704 (1976), and is not contested by the Department. See Pet. App. 7a, 2c-3c.

statute was meant to embrace ICFs and skilled nursing facilities ("SNFs") as well as mental hospitals. Pet., App. A. This is the decision that Connecticut asks this Court to review and overturn.

SUMMARY OF ARGUMENT

I.

The term "institution for mental diseases" ("IMD") as used in the Medicaid law does not encompass nursing facilities, but is confined to mental hospitals. While the term IMD is not defined, the statute does provide that those states electing to cover persons aged 65 and over in IMDs must undertake to develop comprehensive plans for the care of the mentally ill, including establishment of "alternatives" to public institutions for mental diseases," among which "nursing facilities" are specifically listed. 42 U.S.C. §1396a(a)(20) and (21) (the

"Long Amendment"). This provision demonstrates that Congress did not intend the term IMD to include nursing facilities.

Congressional intent to extend Medicaid to intermediate care facilities ("ICFs") (a class of nursing facilities) that serve the mentally ill is shown by the statutory definition of an ICF as an institution providing health care for people with "a mental or physical condition" requiring ICF-level care. 42 U.S.C. §1396d(c). There was no age limit on Medicaid support for care of a mental condition in an ICF.

The interpretation of the term IMD as confined to mental hospitals is powerfully supported by a long legislative record. The term was first used in 1950 to exclude residents of mental hospitals from federally-supported public assistance, since states had traditionally

borne responsibility for those institutions. Thereafter, the term IMD was repeatedly and consistently used as a synonym for mental hospitals. The history of the 1965 law which incorporated the term into Medicaid shows a well-expressed intent to encourage the states to deemphasize reliance on public mental hospitals, the size and nature of which were regarded as inimical to successful treatment of most mental patients, and to develop alternative approaches for treating mental illness. The term IMD was used throughout to refer to mental hospitals in contrast to the alternative kinds of facilities that were to be encouraged, such as nursing facilities. Subsequent legislative history, in connection with the amendments that brought ICFs under the Social Security Act and then into the

Medicaid program, confirm this limited understanding of the term IMD.

The Department regulations, explanatory documents and public statements in the several years following enactment of Medicaid all evidence the understanding of the IMD term as confined to mental hospitals and not extending to nursing facilities. This Court so understood the term when it decided Schweiker v. Wilson, 450 U.S. 221 (1981) and other courts have consistently read the term in the same way.

The Department's change of interpretation, evidenced by internal memoranda prepared in 1975 and 1976, is not faithful to the terms of the statute nor to the decades of history that show that Congress used the term IMD to mean only mental hospitals. Since Middletown Haven was an ICF and was neither a mental

hospital nor did it manifest the undesirable characteristics that caused Congress to limit federal support for mental hospital care under Medicaid, it was wrong to withdraw federal Medicaid funds for Middletown Haven on the ground that it was an IMD.

II.

The disallowance of federal funding for Middletown Haven represents after-the-fact imposition of conditions to federal grant funds not knowingly accepted by Connecticut, and thus constitutes an impermissible use of the constitutional spending power. For this additional reason, the disallowance cannot be sustained.

The disallowance was after the fact because the Department never gave states reasonably reliable notice that the IMD exception would be applied to ICFs, or

how it would be determined that an ICF was an IMD. Not until the Department's audit, which was based on unspecific criteria of dubious validity, could Connecticut know that Middletown Haven would be classified as an IMD.

Medicaid represents an exercise in "cooperative federalism" (Harris v. McRae, 448 U.S. 297 (1980)), establishing a relationship between state and federal governments "in the nature of a contract." Pennhurst State School v. Halderman, 451 U.S. 1 (1981). While the federal government surely retains the right, pursuant to its spending power, to impose conditions on grants of Medicaid funds to states, any such imposition must be unambiguous, so that states know in advance the terms on which they may receive federal support. Id. at 17. Any

other approach threatens havoc to state fiscal management.

Application of the IMD exception to deny funding for Middletown Haven after those funds were received and expended by Connecticut violates the Pennhurst principles.

III.

No deference is due the Department's interpretation of the IMD exception because that interpretation is so contrary to the terms, meaning and purpose of the Medicaid law. Security Industry Association v. Board of Governors, 82 L.Ed.2d 107, 113 (1984). Deference is especially unwarranted in view of the Department's change of position and its failure to articulate and implement its new position in a manner that would permit its reasonable application by states. Deference is also unwarranted because the new federal

interpretation is based on a policy concern for inappropriate placement of people in ICFs that Congress considered and resolved by other means not involving a blanket prohibition on Medicaid participation for ICFs specializing in the care of mental cases.

ARGUMENT

This Court has commented on the nature of the unique relationship between the state and federal governments under the Social Security Act in cases involving private challenges to aspects of state public assistance programs. See King v. Smith, 392 U.S. 309 (1968); Rosado v. Wyman, 397 U.S. 397 (1970); Dandridge v. Williams, 397 U.S. 471 (1970); and Harris v. McRae, 448 U.S. 297 (1980). However, this case is important because it is the first case to reach the Court involving a dispute between the

federal and state governments under the Act. Apart from its bearing on federal-state relations, this case will also have an important impact on the treatment of mental illness in America. The 20th century has been marked by an "expanding concern of society with problems of mental disorders" (Addington v. Texas, 441 U.S. 418, 426 (1979)) and has seen great progress in public and scientific understanding of mental disability and in the discovery of new resources and techniques for treating mental illness. Congress, especially in the last thirty years, has taken a leadership role in the pursuit of more progressive treatment of the mentally ill. But the position maintained in this case by the federal agency undermines the progressive legislative steps of the past three decades.

I. A BRIEF RESUME OF THE EVOLUTION OF
FEDERAL POLICY ON THE PROBLEMS OF
MENTAL ILLNESS.

A. Development and Nature of State
Mental Hospitals.

The mentally ill have not always been treated with compassion and care. Through most of recorded history, they have been the objects of abuse or vilification. In the nation's earliest days the mentally ill, if not exiled, were confined in jails, almshouses or poorhouses. Acceptance of more humane policies came slowly. The first public asylum for the mentally ill was erected in Williamsburg, Virginia in 1773, but several decades passed before another such facility was opened.

There were movements to improve the care of the mentally ill in America during the 19th century. One reformer of particular fame was the legendary Boston

schoolteacher, Dorothea Dix, whose crusade to improve the lot of the incarcerated mentally ill led to the establishment or enlargement of mental hospitals by many states.¹³

State mental hospitals increased rapidly after the Civil War, although the number of available beds was never sufficient to meet the need, and most facilities quickly became overcrowded. Moreover, the ideal of the mental hospital as a place of treatment and cure of all forms of mental disease was quickly dashed, in part by the shortcomings of knowledge and treatment capability, and

¹³ Ms. Dix' efforts at the federal level were less successful. Although she helped to persuade the Congress in 1854 to grant federal lands to finance the construction of state hospitals for the insane, President Pierce vetoed the bill on the ground that the federal government had no business in the field of mental health, or any other aspect of public welfare. VII Messages and Papers of the Presidents 2780-89 (1914 ed.).

the institutions became predominantly custodial in nature.¹⁴

An important development in the late 19th century was the assumption of financial responsibility by the State of New York for the care of its mentally ill, and in the ensuing decades most states followed this lead. Further construction of new state facilities occurred throughout the first half of this century. Yet there was only limited progress in the treatment provided to the institutionalized mentally ill. In the best of facilities, care remained essentially custodial, and substandard or inhumane

¹⁴ David Rothman, in his book "The Discovery of the Asylum," documents the decline of mental hospitals "from a reform to a custodial operation" (p. 265), leading to the "personal revulsion" (p. 295) that was a common reaction to state mental hospitals in the mid-20th century.

conditions abounded.¹⁵ Mental hospitals were widely perceived as permanent places of confinement for those with mental ailments for which no cure or treatment was known. See O'Connor v. Donaldson, 422 U.S. 563, 583 (1975) (Burger, C.J. concurring). By mid-century, the typical public mental hospital housed several thousand patients.¹⁶

B. Establishing the Basis For Federal Policy.

While there were forays into the mental health field by the Army Department

¹⁵ Mary J. Ward's gripping account in "The Snake Pit" riveted public attention after World War II on the deplorable conditions inside many large public mental hospitals.

¹⁶ On the history of the care of mentally ill, see generally A. Deutsch, *The Mentally Ill in America* (2d ed. 1947); D. Rothman, *The Discovery of the Asylum* (1971); R. Connery, *The Politics of Mental Health* (1968); S. Brakel & R. Rock, *The Mentally Disabled and the Law* (rev. ed. 1971). See also R. Rock, *Hospitalization and Discharge of the Mentally Ill* 69-72 (1968).

(Deutsch, supra, at 464-469) the first federal commitment to deal systematically with mental health came with the passage of the National Mental Health Act of 1946. Pub. L. No. 79-487, 60 Stat. 421. The Senate report recommending this Act noted that "[m]ental hospitals provide care principally for the most seriously ill; yet our mental hospitals are today poorly equipped to serve even the limited function of treatment after the illness of patients has become disabling"

The report referred to abusive conditions in a number of institutions. S. Rep. No. 1353, 79th Cong., 2d Sess. (1946), reprinted in 1946 U.S. Code Cong. & Ad. News 1259, 1261-2.

The 1946 Act established the National Institute of Mental Health within the Public Health Service, and authorized aid to states for the development of mental

health services. The work begun as a result of the 1946 Act brought recognition of the need for a more enlightened approach to dealing with mental illness. Accordingly, Congress enacted the Mental Health Study Act of 1955. Pub. L. No. 84-182, 69 Stat. 381. This joint resolution observed that the increasing burden of coping with the problems of mental illness "may well be due primarily to an outmoded reliance on simple custodial care in mental hospitals as the chief method of dealing with mental illness."

The Act called for a study under the auspices of the Surgeon General into the resources and means for dealing with the mentally ill. The aims were ambitious: to prepare a blueprint for replacing the then-current system, characterized predominantly by custodial care in gigantic remote mental institutions, with

new modern means for treating and rehabilitating mental disabilities. See S. Rep. No. 870, 84th Cong., 1st Sess. (1955), reprinted in 1955 U.S. Code Cong. & Ad. News 2530.

Five years later, the Joint Commission on Mental Illness and Health, which had been established under the 1955 statute, issued its final report entitled "Action for Mental Health."¹⁷ The Commission recommended, among other things, that no more state hospitals of more than 1,000 beds be built, that no patient be added to any existing hospital already housing 1,000 or more patients, and that large state hospitals gradually be limited

¹⁷ Joint Commission on Mental Illness and Health, Action for Mental Health (1961) (hereafter cited as "Jt. C. Rep. ____").

to the most severe cases of mental illness. Jt. C. Rep. at xvi, 289-90.¹⁸

The Commission urged greater attention to aftercare and intermediate care as essential components of the service provided to mental patients, such components to include, among other things, nursing homes. The general unavailability of nursing homes qualified and willing to care for disturbed patients and meet their rehabilitative needs was noted, and the need for improvement stressed. Id. at 178-84. It was urged that public expenditures for mental health services be expanded, with the federal government to

¹⁸ The Commission's report, quoting earlier surveys, described state mental hospitals as "dumping grounds" for people with a variety of problems that were difficult to treat. The presence of these socially undesirable persons combined with many elderly and chronic patients seemed conducive to the "custodial and apathetic atmosphere that is a striking feature of our state hospitals, including the better ones." Id. at 175.

share substantially in the increased costs. Id. at xvii, xx, 178-84, 270-71, 286-87.

The Joint Commission Report sparked renewed attention to how governmental action could help to solve the problems identified.¹⁹ One outcome of this renewed interest was enactment of the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, Pub. L. No. 88-164, 77 Stat. 282.²⁰

¹⁹ See Connery, *supra*, at 42; 1 Public Papers of the Presidents: Administration of John F. Kennedy, No. 492, 767 (1961); 108 Cong. Rec. 7849-50 (1962); H.R. Rep. No. 694, 88th Cong., 1st Sess. (1963), reprinted in 1963 U.S. Code Cong. & Ad. News 1054, 1063; Hearings on Social Security Amendments of 1971 Before the Senate Committee on Finance, 92d Cong., 1st and 2d Sess. 934 (1972) (hereafter cited as "1971-72 Senate Hgs.").

²⁰ The House report on this bill described the poor condition of state mental hospitals throughout the nation. Almost 20 percent were found to be fire and health hazards by the standards of their own states. "Only a small percentage of the institutions can be said to be therapeutic
(footnote cont'd)

Even before this, the question of federal assistance in caring for the mentally ill had been addressed in the context of the Social Security Act, and it was an important issue in the debate over a federal role in financing health care that led to the adoption in 1965 of the Medicare and Medicaid programs.

C. Origins of the IMD Provision in the Social Security Act.

The public assistance programs for the elderly (Title I) and the blind (Title X), contained in the Social Security Act of 1935, covered needy people residing in private institutions. However, residents of public institutions of all kinds were

(footnote cont'd)
and not merely custodial." Professional staff inadequacies were widespread. These 278 state hospitals collectively housed over one-half million patients -- an average of almost 2000 patients per institution. H.R. Rep. No. 694, 88th Cong., 1st Sess. (1963), reprinted in 1963 U.S. Code Cong. & Ad. News 1064.

excluded on the theory that the states had assumed responsibility for their maintenance. Act of Aug. 14, 1935, §§3, 1003, 49 Stat. 620, 621, 646; see 1965 S. Rep. 144.

The Act was expanded in 1950 to incorporate aid to the permanently disabled (by reason of physical or mental impairment) and to permit direct payment for medical care as well as for subsistence needs. At the same time, the coverage provisions were modified to permit assistance to some residents of public medical institutions, but to exclude assistance for patients in both public and private institutions for tuberculosis or mental diseases. Pub. L. No. 81-734, §§ 303, 343, 351, 64 Stat. 549, 554,

557-58.²¹

This was the first use in the law of the term "institution for mental diseases." The new provision originated in a study by a panel of distinguished citizens, known as the Advisory Council on Social Security, established pursuant to Senate Resolution No. 141, 80th Cong., 1st Sess. (1947). The Council's report (Senate Document No. 208, 80th Cong., 2d Sess. (1949)) became the foundation for the 1950 amendments. Even on this first occasion, it was evident that the exclusion was intended to refer to mental hospitals. Though aware of the limits of the original Social Security Act, the Council thought that "the Federal Govern-

²¹ Patients in medical institutions (general hospitals) who were diagnosed as tuberculosis or psychosis cases were also excluded from coverage. Id.

ment should participate in payments made to or for the care of old-age-assistance recipients living in public medical institutions other than mental hospitals." Id. at 114 (emphasis added).²² The Advisory Council pointed to a substantial number of elderly people living in nursing homes. Id. at 115.²³ Its recommendation for expanding coverage to institutionalized persons encompassed them (id. at 116), which further shows that

²² The exclusion of mental hospitals from coverage of the old-age assistance program was understandable. Consideration of the National Mental Health Act in 1946 had emphasized the enormous number of people -- close to one-half million -- in state mental hospitals. States had traditionally borne the cost burden of those facilities, and there was no impetus to shift part of that large bill for caring for the elderly poor to the federal treasury.

²³ The Advisory Council recommended the establishment of standards for nursing homes whose residents were to be covered, and this recommendation was also accepted. Pub. L. No. 81-734, §301(b), 64 Stat. 548; S. Rep. No. 1669, 81st Cong., 2d Sess. 58-9 (1950).

the IMD exception applied only to mental hospitals.²⁴

An effort was made to eliminate the IMD exception in 1960. In that year Title I was augmented by a program of medical assistance to the aged.²⁵ The bill as reported contained an IMD exception, described in the reports as an exclusion for "services rendered in mental ... hospitals." S. Rep. No. 1856, 86th Cong., 2d Sess. 7, 111 (1960); H.R. Rep. No. 1799, 86th Cong., 2d Sess. 7, 133-34

²⁴ The House Committee on Ways and Means, which initiated the bill that became law in 1950, relied upon the recommendations of the Advisory Council, and its discussion of the amendments relating to institutionalized persons followed closely the discussion in the Advisory Council's report. See H.R. Rep. No. 1300, 81st Cong., 1st Sess. 5, 42, 152 (1949). The Senate Finance Committee adopted the House view. S. Rep. No. 1669, 81st Cong., 2d Sess. 58, 175 (1950).

²⁵ This new program covered those whose income was not so low as to qualify them for cash assistance. Pub. L. No. 86-778, §601, 74 Stat. 991.

(1960). An amendment to eliminate the IMD exclusion was adopted by the Senate, although there was substantial dissent because of the high cost of assuming responsibility for the care of the elderly in mental hospitals. 106 Cong. Rec. 16001-16006 (1960). The amendment was dropped in conference. H.R. Rep. No. 2165, 86th Cong., 2d Sess. 27 (1960).²⁶

Thus, by the time of passage of the Medicaid law in 1965, there had been considerable attention devoted to the problem of mental illness. The Joint Commission had strongly recommended steps to deemphasize reliance on large, essentially custodial mental hospitals, and

²⁶ The 1960 legislation did modify the prohibition on coverage of psychotics and tuberculars in general hospitals (note 21, page 35, supra) by permitting federal support for the first seven weeks of their hospitalization. Pub. L. No. 86-778, §601(a), 74 Stat. 991.

had stressed the need for alternative approaches, including intermediate facilities like nursing homes. Congress had twice determined to exclude coverage of the needy elderly, blind and disabled in institutions for mental diseases because of a disinclination to assume the large cost burden for mental hospital care that had been borne by the states. There was not the slightest indication that the IMD exclusion covered any facility other than a mental hospital.

D. Expansion of Support for Care of the Mentally Ill Under Medicaid
-- The Long Amendment.

National health care financing proposals were advanced continuously since Franklin D. Roosevelt became President but provoked great controversy and were

never adopted.²⁷ But by 1965 the tide had turned. As President Johnson relates, the dramatic turning point came in a session of the Ways and Means Committee on March 2, 1965, when Chairman Mills agreed to support not only health insurance for the elderly (Medicare) but also expanded medical assistance for the needy (Medicaid), modeled on the medical assistance program for the elderly adopted in 1960.²⁸

The Ways and Means Committee announcement of the results of its historic session, in summarizing the new Medicaid program, advised that

²⁷ See, e.g., W. Cohen, "The Development of the Social Security Act of 1935: Reflections Some Fifty Years Later," 68 Minn. L. Rev. 379, 383-87 (1983); K. Davis, "The Birth of Social Security," 30 American Heritage 38 (April/May 1979); H. Truman, Years of Trial and Hope 19-23 (1956); 108 Cong. Rec. 14628, 19130 (1962).

²⁸ L. Johnson, The Vantage Point 214-16 (1971).

"present limitations on Federal participation in public assistance to aged individuals in tuberculosis or mental disease hospitals would be removed under certain conditions." House Committee on Ways and Means, 89th Cong., 1st Sess., Summary of Decisions by Committee on Health Insurance, etc. 1 (Comm. Print 1965) (emphasis added).

The conditions were also summarized in the release. The Committee's proposal required

"as a condition of Federal participation in such payments to, or for, mental patients certain agreements and arrangements to assure that better care results from the additional Federal money." Id. at 15.

Together with the community mental health center legislation enacted two years earlier, these provisions, which were adopted by both houses as part of the Medicaid law (42 U.S.C. §1396a(a) (20) and (21)), formed the foundation for a transformation of care of the mentally ill, as urged by the Joint Commission on

Mental Illness and Health.²⁹ In the ensuing two decades there has been a major shift in the settings in which mentally disturbed people are treated -- away from large, remote mental hospitals and toward nursing homes, clinics and other community-based facilities.³⁰ At the same time, in significant measure custodial care has been displaced by treatment in accordance with individually-developed plans that bring the great advances in the knowledge about causes and cures of mental illness to bear on the hundreds of

²⁹ The new provisions were also incorporated into Title I (aid to the aged). In addition, the 1965 law deleted provisions in all titles limiting the extent of coverage available to psychosis and tuberculosis cases in general hospitals. See 1965 S. Rep. 144, 216-17.

³⁰ Between 1960 and 1980 the occupancy of public mental hospitals dropped from 536,000 to 140,000 patients. 1 Historical Statistics of the United States (1975 ed.), p. 84; Statistical Abstract of the United States, 1982-83, pp. 112, 118.

thousands of citizens afflicted with mental disabilities.³¹

This was the purpose of the provisions that were summarized in the Ways and Means Committee release, and which are known as the "Long Amendment" because they were first put forward by Senator Long and adopted by the Senate during its consideration of Social Security Act amendments in 1964. 110 Cong. Rec. 21346-49 (1964). As the quid pro quo for federal support for the elderly in mental hospitals, the states had to undertake to improve the means of care and treatment of mentally ill citizens, through establishment of joint working relationships

³¹ See, e.g., Hearings on Social Security Amendments of 1967 Before the Senate Committee on Finance, Part 1, 90th Cong., 1st Sess. 400-04 (1967). The number of professional staff per patient in public mental hospitals more than quadrupled between 1960 and 1980. See statistical sources, note 30, page 42, *supra*.

between welfare agencies and mental health authorities, and by insuring individual plans of care for institutionalized patients that were periodically reviewed and revised, affording appropriate treatment within the institution, and taking steps to develop alternatives to mental hospital care for the mentally ill. 42 U.S.C. §1396a(a)(20).¹²

This last condition was especially important. Under the Long Amendment, in order to receive federal support for care

¹² These provisions applied if a state Medicaid plan covered the elderly in either public or private IMDs. But the focus of attention throughout consideration of the issue was on public mental hospitals, which housed the overwhelming number of affected patients, and whose characteristics had been so forcefully brought forward by the report of the Joint Commission and in other well-publicized accounts. The number of patients in private mental hospitals remained between 13,000 and 14,000 nationwide between 1960 and 1980. See statistical sources, note 30, page 42, *supra*.

of the elderly in public mental hospitals, it was required that the state show

"satisfactory progress toward developing and implementing a comprehensive mental health program, including provision for utilization of community mental health centers, nursing facilities, and other alternatives to care in public institutions for mental diseases." 42 U.S.C. §1396a(a)(21).

This theme was stressed in the extensive discussion of the Long Amendment in the Committee reports, both of which identified "nursing homes" as among the alternatives to mental hospitals that were to be encouraged. 1965 S. Rep. 144-47; H.R. Rep. No. 213, 89th Cong., 1st Sess. 126-29 (1965) (hereafter cited as "1965 H. Rep.").¹³

¹³ The Committees in this respect were following the recommendation of President Johnson, whose message submitting health legislation in 1965 referred to the emerging "new era in the prevention, treatment and care of mental illness" and admonished that "mere custodial care of patients in large, isolated asylums is clearly no longer
(footnote cont'd)

E. Extension of the Social Security Act To Cover Intermediate Care Facilities.

Although Medicaid was a great advance in meeting the health needs of the indigent, there were gaps in its coverage. One such gap related to persons with less severe disabilities who required residential care but of a less intensive and confining nature than was typical of hospitals or skilled nursing facilities. To deal with this situation, Congress added a new Title XI to the Social Security Act in 1967, authorizing federal support for payment for services to aged, blind or disabled people eligible to participate in the cash assistance programs who resided in intermediate care facilities. An ICF had to provide more

(footnote cont'd)
appropriate." H.R. Doc. No. 44, 89th Cong., 1st Sess. 5 (1965).

than mere room and board care, although less than is required for a skilled nursing home. The new law covered people in ICFs "because of their physical or mental condition." Pub. L. No. 90-248, §250, 81 Stat. 920 (1968).^{3*} The law was designed to allow States to move substantial numbers of welfare recipients from skilled nursing homes (which were covered by Medicaid) to lower cost institutions. S. Rep. No. 744, 90th Cong., 1st Sess. 29, 188-89 (1967).

In 1971, the authorization for federal support of ICF care was transferred to the Medicaid title, thereby extending coverage to the near poor as well as those who were eligible for cash assistance under the adult assistance programs.

^{3*} Although the law was entitled "Social Security Amendments of 1967," it was not signed by the President until January 2, 1968.

Pub. L. No. 92-223, §4, 85 Stat. 809.

The basic definition of ICF was carried over from the 1967 legislation.³⁵ 42

U.S.C. §1396d(c).³⁶

The incorporation of ICFs into the Act was critical to achieving the objectives of the Long Amendment of encouraging alternatives to mental hospitals for the care of the mentally ill. ICF care has expanded significantly since it was brought under the Social Security Act,

³⁵ A provision was added that an ICF did not include, for persons under age 65, a public institution for mental diseases or mental defects, "except as provided in subsection (d)." The latter defined mental retardation facilities eligible for Medicaid coverage. This added provision grew out of debates over the extent of coverage of public mental retardation institutions. See note 43, pages 59-60, *infra*.

³⁶ A further broadening of federal support for the care and treatment of mental patients occurred in 1972 when Medicaid coverage was extended to children in mental hospitals under specified conditions that would assure active psychiatric treatment of their mental problems. Pub. L. No. 92-603, §299B, 86 Stat. 1460.

reflecting the substantial need throughout the nation for ICF-level care of people with either physical or mental conditions (or both) that prevent them from living independently.³⁷

II. MIDDLETOWN HAVEN QUALIFIED AS A MEDICAID PROVIDER UNDER THE STATUTE.

A. Medicaid Covers ICFs Treating People Whose Mental Condition Creates Their Need For Care.

Section 1905(c) of the Act (42 U.S.C. §1396d(c)) defines an ICF as an institution that provides health-related care and services to individuals who "because of their mental or physical condition" require care and services, above the level of mere room and board, that can only be provided in an institutional

³⁷ By the end of 1979 there were over 10,000 certified ICFs participating in the Medicaid program, in addition to over 7,000 skilled nursing facilities. The Medicare and Medicaid Data Book, 1981 at 122 (DHHS, April 1982).

setting. The statute requires that the ICF meet service and safety standards established by DHHS.

Between 1977 and 1979, Middletown Haven satisfied the statutory requirements to be an ICF. It met all of the standards established by the Secretary. Far from there being any question about that, Middletown Haven was applauded by the responsible professional federal reviewer as an "ideal ICF" and an "excellent facility." J.A. 11c, 19c. The only basis for seeking recovery of the federal support that had been given for Middletown Haven was that it specialized in the care of people with mental conditions, including those discharged from state mental hospitals, thereby allegedly making it an IMD and ineligible for

federal financial support."

- B. The IMD Provisions of the Statute Do Not on Their Face Preclude Coverage For ICFs Specializing in Care of Residents With Mental Conditions.
-

"[T]he starting point for interpreting a statute is the language of the statute itself." Consumer Product Safety Commission v. GTE Sylvania, Inc., 447 U.S. 102, 108 (1980). In this case there is no express statutory definition of the term "institution for mental diseases." But there is an express statement of what

¹⁸ While Middletown Haven was a model ICF, it is important to stress that it did not attempt to meet the more exacting standards established by DHHS regulations for institutions furnishing the higher level of care expected of mental hospitals participating in the Medicaid program. See 42 C.F.R. §§442.303, 442.333, 442.346 (1983) and compare the stricter requirements for staff ratios and qualifications and service programs in 42 C.F.R. §§405.1036 and 405.1038 (referred to by 42 C.F.R. §440.140(a) (1983)). For example, Middletown Haven did not admit "acute mental disorder" cases (J.A. 43a) and its physician-psychiatrists worked only part-time at the facility. J.A. 2c-3c.

that term does not include. It is contained in section 1902(a)(21) (42 U.S.C. §1396a(a)(21)), which defines "nursing facilities" (as well as "community mental health centers") as alternatives to "public institutions for mental diseases."

Notwithstanding this specific statutory statement, the Department relies on two other provisions of the statute that use the term "institution for mental diseases" to support its view that the term embraces nursing facilities. One is contained in the description of ICF services that was added in 1971 to the list of services covered by Medicaid. That description is:

"intermediate care facility services (other than such services in an institution for tuberculosis or mental diseases) for individuals who are determined ... to be in need of such care." 42 U.S.C. §1396d(a)(15) (emphasis added).

Looking just at the statute alone, the parenthetical phrase in sub-paragraph (15) states that ICF-level services are not covered if provided in a tuberculosis or mental disease institution. That ICF services might be provided other than in an ICF is expressly contemplated by the statute."

Thus, the parenthetical phrase in sub-paragraph (15) does not mean that ICFs

" See section 1905(c) (42 U.S.C. §1396d(c)), providing that ICF-level services may be furnished in a skilled nursing facility or a hospital. DHHS regulations also recognize that ICF services may be furnished in various settings, including a mental hospital. See, e.g., 42 C.F.R. §440.150(d) (1983) (providing that the term "intermediate care facility services" may include services furnished in a distinct part of a facility other than an ICF if the distinct part meets certain standards); 42 C.F.R. §442.254 (1983) (setting standards for hospitals and skilled nursing home facilities offering ICF services). Congress has also recognized the need to use hospitals to provide long-term ICF services, especially where there are insufficient ICFs in the community to meet the demand. See Omnibus Budget Reconciliation Act of 1980, Pub. L. No. 96-499, 94 Stat. 2599, 2609.

can themselves be IMDs, but only that federal support is not available for ICF-level services furnished in an IMD.⁴⁰ As has already been demonstrated, this provision carries out the powerful Congressional preference for deemphasizing reliance, for the care of the mentally ill, on the large, remote and forbidding institution that was the Congressional conception of a mental hospital.⁴¹ That

⁴⁰ While Petitioner asserts that the Department's position is not supported by the statute on its face, it recognizes, as has this Court (see *Schweiker v. Gray Panthers*, 453 U.S. 34, 43 (1981)), that the Medicaid statute is far from a model of clarity. Petitioner's argument as to the meaning of the statute on its face involves a literal reading of the statutory terms, although no more literal than is called for by the immensely complex statutory draftsmanship involved. That the literal reading accords with Congressional intent is amply demonstrated by the full history of the statutory provisions and concepts involved, which is detailed in section III infra.

⁴¹ Private psychiatric hospitals might not have exhibited these characteristics; however, Congress did not differentiate between public and private
(footnote cont'd)

preference answers the assertion of the court below that it could "perceive no reason whatsoever to conclude that Congress intended to deter the development of ICF's within the traditional hospital." Pet. App. 9a.⁴²

The second provision on which the Department relies is the general exception that follows the entire list of Medicaid-covered services for "care and services for any individual who has not attained 65 years of age and who is a

(footnote cont'd)
institutions in the IMD provision, although the predominant if not exclusive focus was on the very singular characteristics of public mental hospitals, which housed over 95 percent of the residential mental patients.

⁴² The court's statement that no congressional purpose calling for "... an artificial distinction [between an ICF operating within an IMD and an independent ICF] has been offered, and we have found none in our independent research," (Pet. App. 9a) betrays a lack of understanding of how mental hospitals had evolved and the strong adverse reactions to them of government officials and professional experts.

patient in an institution for tuberculosis or mental diseases." 42 U.S.C. §1396d(a)(18)(B). This is the successor to the original IMD provision first adopted in 1950 in connection with the adult assistance titles of the Act.

Even aside from the showing below that Congress meant the term IMD to describe only mental hospitals, this provision cannot be read to preclude Medicaid coverage for ICFs specializing in the care of people with mental conditions. For when this provision was adopted, ICFs were not yet a part of the Medicaid program. When they were subsequently brought under the program, they were defined as facilities caring for people with mental (as well as physical) conditions without age limitation. This was a much more particularized statement by Congress of its intention than is

contained in the general IMD exception. This later, more specific expression of intent controls over the earlier, more generalized provision. See Morton v. Mancari, 417 U.S. 535, 550-51 (1974); Bulova Watch Co. v. United States, 365 U.S. 753, 758 (1961). To hold otherwise and apply the IMD exception to ICFs would require the conclusion that Congress, without any reference to the IMD provision, meant to undo the very act that it had taken in adding to the statute ICF coverage for eligible people of all ages with mental conditions.

The court below sought to avoid that contradictory conclusion by suggesting that the reference to "mental condition" in the definition of an ICF "may" mean something less than all mental patients. It speculated that it could mean only mental patients over 65, or perhaps only

mentally retarded people, or perhaps mental cases in ICFs that did not specialize in their care. Pet. App. 8a. Yet the terms of the statute do not embrace any of these limitations, and the court cited no evidence to suggest that Congress meant any such limitations to be engrafted on to its use of an unconditional term.

The court below also relied on the final sentence in the statutory definition of an ICF. That sentence states:

"With respect to services furnished to individuals under age 65, the term 'intermediate care facility' shall not include, except as provided in subsection (d) ... any public institution or distinct part thereof for mental diseases or mental defects." 42 U.S.C. §1396d(c).

Subsection (d) brings within the ambit of Medicaid coverage services in public institutions for the mentally retarded, provided that a number of very specific

conditions, not pertinent to general ICF care, are met. To the extent it applies to this case the last sentence supports the State, for it is confined to "public" institutions, and under normal rules of English this would convey the meaning that private ICFs for mental diseases or defects, like Middletown Haven, are to be covered by Medicaid.⁴³

⁴³ The last sentence of the ICF definition, which was not included in the definition when ICF coverage was under Title XI, had its origin in H.R. 17550, Social Security Act Amendments introduced by Ways and Means Committee Chairman Mills and adopted by that Committee and the House. The stated purpose of the provision (H.R. Rep. No. 1096, 91st Cong., 2d Sess. 124 (1970)) was to eliminate federal support for care in public institutions, particularly those for the mentally retarded, which a few states were seeking to bring within the ambit of Title XI. See Hearings on Social Security Amendments of 1970 Before the Senate Committee on Finance, 91st Cong., 2d Sess. 505-15, 1185 (1970) (hereafter cited as "1970 Senate Hgs."). That effort had been fostered by a Departmental interpretation that federal support for care in institutions for the mentally retarded was available without regard to age and without the kind of commitment to better treatment that
(footnote cont'd)

In short, taking the statute on its face, the ordinary meaning of the definition of ICF would clearly encompass such facilities that specialize in the care of patients with mental conditions, and the references to IMDs do not warrant the contrary conclusion.

C. Legislative and Administrative History Confirms That the IMD Exclusion Applies Only To Mental Hospitals.

1. Evolution of the IMD Exception

State assumption of responsibility for the care of the mentally afflicted in

(footnote cont'd)
the Long Amendment required for coverage of the aged mentally ill in IMDs, as long as the facility otherwise met the definition of a hospital or a nursing home. See Handbook, §D-4620.

The House provision was incorporated into the ICF definition by the Senate Finance Committee in connection with its first proposal to bring ICFs under the Medicaid program. S. Rep. No. 1431, 91st Cong., 2d Sess. 147 (1970). The Senate adopted the proposal as part of a package of Social Security Act amendments. 116 Cong. Rec. 43868 (1970).

public mental hospitals has been a prominent fact of life for over a century, and Congress deferred to that assumption of responsibility when it developed the public assistance programs under the Social Security Act. But the deference was no broader than the extent of the assumption of responsibility. There was no comparable record of state support for the mentally ill in other settings, such as nursing facilities. In fact, as the Joint Commission later found, the nation's care of its mentally ill was deficient because of the unavailability of such resources. Because there was no predicate for federal abstention beyond mental hospitals, the intent and purpose of the IMD exception was confined to that setting, as is shown in the report of the Advisory Council on Social Security that initiated the IMD exception

in 1947, the Congressional report embracing the recommendation, and the 1960 debates over whether the exception should be removed. See pages 33-38, supra.^{**}

The reports and debates that produced the 1965 Medicaid legislation abound with evidence of intent to keep the IMD clause confined to mental hospitals. The Long Amendment, which narrowed the IMD exclusion for Medicaid (for persons over 65) in return for state commitment to development of comprehensive programs for

^{**} The 1960 amendments adopted the program of medical assistance for the aged, the precursor to Medicaid. Pub. L. No. 86-778, §601, 74 Stat. 924, 991. An IMD exception was included in that program in terms identical to those used in the 1950 law and in the subsequent Medicaid law (but for the over-65 exception). During the consideration of the Medicare-Medicaid legislation, the House Ways and Means Committee issued a document describing the 1960 exception as applying to services furnished to patients in "mental hospitals." House Committee on Ways and Means, 89th Cong., 1st Sess., Summary of Major Provisions of Medical Assistance for the Aged Program 1 (Comm. Print 1965).

the care of the mentally ill, including alternatives to care in IMDs, was first adopted as a Senate floor amendment to a 1964 bill, and grew out of discussions between Senator Long, Senator Carlson of Kansas and DHEW. 110 Cong. Rec. 21348-49 (1964).^{**} Both Senators Long and Carlson emphasized the importance of developing alternatives to the "traditional large State mental hospitals" (id. at 21349) and identified nursing homes as among the alternatives to IMDs that were to be encouraged. Id. at 21348, 21349.

^{**} The Senate Finance Committee had adopted a provision simply eliminating the IMD exclusion from the adult assistance titles of the Social Security Act, as the Senate had unsuccessfully sought to do in 1960. See pages 37-38, supra. 110 Cong. Rec. 21085 (1964); S. Rep. No. 1513, 88th Cong., 2nd Sess. 7, 17 (1964). The subsequent discussions led to inclusion of the provisions intended to encourage state comprehensive mental health planning, including development of alternative settings.

This theme permeated the extensive discussion of this subject in the Committee reports on the 1965 legislation, 1965 H. Rep. 126-29 and 1965 S. Rep. 144-47.⁶⁶ The entire tenor of the reports is to distinguish between the traditional large state mental hospital and more modern settings and approaches, including nursing homes, for treating the range of conditions that are grouped under the general heading of mental illness.⁶⁷

⁶⁶ Because of the significance of these reports (which are similar in content) there is attached hereto as Appendix B the relevant excerpt from the Senate Finance Committee Report.

⁶⁷ The Long Amendment, in addition to limiting the IMD exception as incorporated into the new Medicaid program, applied also to the titles of the Act under which income assistance was provided to the aged, blind and disabled. In the latter two categories, an exclusion for care in IMDs was retained, but limitations on the care of mental illness in general hospitals were eliminated. See 1965 H. Rep. 193-94; 1965 S. Rep. 216-17.

Given this explicit and extensive statement of Congressional intent, and the resultant statutory provisions that describe nursing facilities and community mental health centers as among the alternatives to IMDs (42 U.S.C. §1396a(a)(21)), it is not possible to credit the Department's position that when Congress used the term "institution for mental diseases" in defining medical assistance in the new Title XIX, it meant that term to extend broadly beyond the traditional mental hospital to include nursing homes.⁶⁸

⁶⁸ There is another indication to support petitioner's interpretation of IMD. The 1965 law extended Medicaid coverage, for people of all ages, to treatment of psychosis or tuberculosis cases in public general hospitals. In this respect, the law finally interred an exception that had been adopted in 1950 (see note 21, page 35, supra) and partially repealed in 1960 (see note 26, page 38, supra). Under the Department's interpretation, these psychosis or tuberculosis (footnote cont'd)

The reference on which the Department has principally relied is the parenthetical clause "other than such services in an institution for tuberculosis or mental diseases" that appears in the listings of inpatient hospital services, skilled nursing facility services and intermediate care facility services in the section defining covered Medicaid services. 42 U.S.C. §1396d(a)(1), (4) and (15). These parenthetical clauses were not included when the list of covered services first appeared in the 1960 legislation adopting the program of medical care for the elderly poor. Pub. L. No. 86-778, §601, 74 Stat. 924, 991.

(footnote cont'd)

cases, if under age 65, would lose Medicaid eligibility upon discharge from a public general hospital into an ICF that specialized in the care of such cases. This result, which discourages the use of the less intensive and less costly care setting, is directly in conflict with well-expressed Congressional objectives.

Their inclusion was unnecessary because of the general IMD exclusion that appeared at the end of the list of covered services (as does the modified IMD provision in the Medicaid law). The question then is why these parenthetical clauses were added when the listing of services was incorporated into Title XIX in 1965.⁴⁹

The Senate Report supplies the answer. As in the 1960 law, certain of the listed services were mandatory -- they had to be provided in order for the state to qualify its program. Inpatient hospital services and skilled nursing facility services for people over 21 were among the mandatory services. See 42 U.S.C.

⁴⁹ This discussion relates to the provisions for inpatient hospital and skilled nursing facility services, since the ICF provision was not part of the 1960 law and was not added to Title XIX until 1971.

§1396a(a)(10). The purpose of the parenthetical clause was to "help make it clear that it is optional rather than mandatory for a State to include services for the aged in tuberculosis or mental institutions." 1965 S. Rep. 81. It is a fair conclusion, since there is no legislative evidence to the contrary, that no broader purpose was intended when the identical parenthetical clause was included in the definition of ICF services when it was added to the law in 1971.

2. Congressional Acknowledgment of the Limited Scope of the IMD Exception

Congressional references to the IMD exception since enactment of the Medicaid Act in 1965 confirm that it was meant to embrace only mental hospitals and not other categories of facilities that care for the mentally ill.

When it was proposed in 1971 to bring ICFs under Medicaid, Senator Long on behalf of the Senate Finance Committee explained:

"The committee amendment is designed to make it clear that intermediate care coverage is for persons with health-related conditions who require care beyond residential care or boarding home care, and who, in the absence of intermediate care would require placement in a skilled nursing home or mental hospital." 117 Cong. Rec. 44721 (1971) (emphasis added).

The Department's current notion, that ICFs specializing in the care of mental patients are barred from Medicaid participation by the IMD clause, cannot be squared with this statement of intent to cover under Medicaid, without age limitation, facilities that care for patients who, absent the availability of ICFs, would be placed in mental hospitals.

In 1972, when the Act was amended to provide federal support for "inpatient

psychiatric hospital services" for children, the Senate Finance Committee again equated institutions for mental diseases with mental hospitals.⁵⁰

Finally, the version of the 1972 Amendments adopted by the Senate contained a provision authorizing demonstration projects to evaluate the extension of "medicaid inpatient mental hospital coverage" to the mentally ill between the ages of 21 and 65. H. R. 1, §299B (as passed by the Senate on October 5, 1972); S. Rep. No. 1230, supra, at 281. The proposal was dropped in conference. H.R. Rep. No. 1605, supra, at 65. It is hard

⁵⁰ S. Rep. No. 1230, 92d Cong., 2d Sess. 281 (1972). See also H.R. Rep. No. 1605, 92d Cong., 2d Sess. 65 (1972). If the Department's view is correct, it means that in 1972 Congress deliberately amended the law to permit Medicaid coverage for children in the most expensive type of facility (psychiatric hospitals) but declined to cover them when cared for in less expensive and more accessible facilities like ICFs.

to believe, in light of all that had gone before, that the Senate would take a step toward eliminating the IMD exception for all mental hospital cases, but leave it in place for those under 65 in alternative, smaller, and less remote facilities like nursing homes. This Senate action adds still further confirmation to the conclusion that the IMD exception was never intended to apply to such facilities in the first place.⁵¹

⁵¹ Also in 1972 there was a "technical" amendment to the listing of covered Medicaid services to add "intermediate care facility services" to 42 U.S.C. §1396d(a)(14), which previously had listed inpatient hospital services and skilled nursing facility services for individuals 65 years of age or older in an institution for tuberculosis or mental diseases as eligible for Medicaid. As stated by the Senate Finance Committee, where the provision originated, the purpose of the amendment was to make clear that Medicaid coverage was available for ICF services to the elderly even when provided in mental institutions. S. Rep. No. 1230, supra, at 321. Contrary to arguments of the Department, this change did not "prove" that ICFs could themselves be IMDs. Rather, it
(footnote cont'd)

3. Administrative Recognition of the Limited Scope of the IMD Exception

The responsible administrative officials prior to and at the time the Medicaid law was developed were fully aware that the IMD exception extended only to mental hospitals. This was the explanation given by DHEW Secretary Celebrezze to the Senate Finance Committee in 1964. He reported "[t]he main reason for this exclusion is that most of these hospitals are public institutions and are supported by public funds."

Hearings on H.R. 11865 Before the Senate Committee on Finance, 88th Cong., 2d Sess. 108 (1964) (emphasis added).¹²

(footnote cont'd)
confirms the Congressional awareness that ICF services might be made available in mental hospitals. See page 69, supra.

¹² Senator Ribicoff, who preceded Mr. Celebrezze as HEW Secretary, likewise referred to the IMD
(footnote cont'd)

The Department acted on this understanding after Medicaid was enacted. In June 1966, it issued Supplement D to the Handbook of Public Assistance Administration, setting forth the initial regulations to implement Medicaid.¹³ The Handbook equated an IMD with a mental hospital; it required, in order for an IMD to qualify for coverage of its over-65 patients, that the institution meet the requirements for a psychiatric hospital under the Medicare law (although for three years an IMD could qualify if it was licensed as a mental hospital under state law and met other standards).

(footnote cont'd)
exclusion as a "restriction on Federal participation in assistance programs where the recipients are in mental or tuberculosis hospitals" and the state had assumed responsibility for their care. 111 Cong. Rec. 15805 (1965) (emphasis added).

¹³ The Handbook was then the source of regulations to carry out the Social Security Act. See King v. Smith, 392 U.S. at 319 n.16 (1968).

Handbook, §D-5141.14(d).⁵⁴ Essentially the same provisions were incorporated into the formal regulations first published in 1969. 45 C.F.R. §249.10(b)(14) (iv) (1970).

If the Department's current position that the term IMD embraces nursing facilities is correct, it means that immediately after Medicaid was passed, and notwithstanding the emphasis in the Long Amendment on the importance of moving people out of mental hospitals and into alternative facilities, DHEW defined an IMD eligible for federal support for patients over 65 solely in terms of a

⁵⁴ The Handbook also contained a statement of the exclusion of any individual under age 65 who is a "patient in an institution for ... mental diseases; i.e., an institution whose overall character is that of a facility established and maintained primarily for the care and treatment of individuals with ... mental diseases (whether or not it is licensed)." Handbook, §D-4620.2 (Pet. App. 16d).

mental hospital, and thereby precluded financial support for residents over 65 in skilled nursing facilities specializing in care of mental conditions. There is no evidence that the Department meant such an emasculation of the well-elaborated Congressional purpose. Rather, the limitation of the IMD definition to hospitals is a powerful indicator of the limited scope then ascribed to the statutory exclusion.

The Department's understanding of the limited scope of the IMD exception was also manifest in a Report supplied at the request of the Senate Finance Committee.⁵⁵ After identifying the "specific statutory exclusion of payment for care

⁵⁵ DHEW, Social Security Administration, Office of Research and Statistics: Financing Mental Health Care Under Medicare and Medicaid (Research Report No. 37) (1971) (hereafter cited as "Report").

of patients under the age of 65 in mental institutions" (emphasis in the original) the Report listed "[s]ervices important in the treatment of the mentally ill covered under Medicaid" (emphasis added) and included skilled nursing home services and services in psychiatric wards of general hospitals, among others. Report, supra, at 36.⁶⁶ (ICF services were not listed because, at the time of the Report, Medicaid had not been amended to incorporate ICFs.) An appendix summarizing the legislative history of federal financing of psychiatric services describes the IMD exclusion as a limitation on mental hospital coverage. Report,

⁶⁶ The Report later pointed out that the IMD exclusion for persons under age 65 precluded Medicaid payment for inpatient hospital services or skilled nursing home services in a "psychiatric institution." Report, supra, at 39-40.

supra, at 47-49.⁶⁷

That the Department did not view the IMD exclusion as going beyond mental hospitals to embrace nursing homes that specialized in the care of the mentally ill is evident from the regulations adopted to implement Title XI when it was added to the law in 1967 to permit payment for services to the aged, blind and disabled in ICFs. Interim Policy Statement No. 23, 33 Fed. Reg. 12925 (1968), modified 34 Fed. Reg. 9782 (1969), 42 C.F.R. §234.130 (1970). The regulations define an ICF in terms of caring for people with physical or mental conditions, without any intimation that an ICF specializing in the care of mental conditions would be deemed an IMD and

⁶⁷ The cited portions of the Report are attached hereto in Appendix C.

disqualified."¹¹ The omission was not inadvertent. The regulations do make reference to the other major exclusion from coverage in the public assistance titles -- that for public institutions (other than medical institutions). See pages 33-34, supra.¹² The failure in this context to mention the IMD exclusion is yet another sign that responsible officials did not understand it to apply beyond the narrow confines of mental hospitals.¹³

¹¹ There was an IMD provision in each of the adult assistance titles. See page 34, supra.

¹² The "public institution" exception was included in the Medicaid program. 42 U.S.C. §1396d(a)(18)(A).

¹³ In 1970, then-DHEW Secretary Richardson proposed a differentiated matching rate schedule to encourage greater use of ICFs, which offered a "more appropriate level" of care for many residents of skilled nursing facilities and "mental institutions." 1970 Senate Hqs. 68-69. The Secretary's rationale extended to all mental

(footnote cont'd)

The opposite view adopted later by the Department, which is so out of keeping with the purposes of the Medicaid statute as expressed in the Long Amendment, did not prevail during the critical years after Medicaid was enacted and up through the time that intermediate care facilities were brought under the program. Thus, the relevant contemporaneous administrative history is consistent with the legislative history -- the IMD exclusion was meant to apply to mental hospitals, and not to nursing homes and the other alternative settings for the care of the mentally ill.

4. The Courts' Understanding of the IMD Exclusion

While the precise scope of the IMD

(footnote cont'd)
hospital patients, not just those 65 and over (id. at 78-80), showing that the Department still did not view the IMD exception as applying to ICFs.

clause has never been before this Court for decision, the Court has considered it and has characterized it as referring to mental hospitals. In Schweiker v. Wilson, 450 U.S. 221 (1981), the issue was the constitutionality of a provision of the Supplemental Security Income program that was affected by the IMD exclusion.⁶¹ The Court quoted the legislative history to the effect that the reason for the exclusion was that "long-term care in such hospitals had traditionally been accepted as a responsibility of the States." Id. at 237 n.19 (emphasis added).

The dissenting opinion in Schweiker v. Wilson was even more explicit in re-

⁶¹ The question in that case was whether the payment of subsistence allowances to certain SSI recipients residing in institutions, but not to those aged 21 through 64 in IMDs, created a constitutionally impermissible classification.

ferring to the IMD exclusion in terms of mental hospitals. It stated:

"The residual exclusion of large state institutions for the mentally ill from federal financial assistance rests on two related principles: States traditionally have assumed the burdens of administering this form of care, and the Federal Government has long distrusted the economic and therapeutic efficiency of large mental institutions." Id. at 242 (citing the 1965 legislative history).

The dissent added, "Residence in a public mental hospital is rationally related to whether the Congress should pay for the patient's treatment." Id. at 246 (emphasis added).

Neither the majority nor dissenting opinions gave any indication that the term "institution for mental diseases" might apply to alternative care settings such as intermediate care facilities. On the matter of relevance to this case, the Court in Schweiker was unanimous in confining the IMD exclusion to mental

hospitals.⁶²

5. The Faulty Analysis of the
Court of Appeals

Against all of this evidence, the court below concluded that the IMD exclusion was meant to encompass not just mental hospitals but any kind of residential care facility for the mentally

⁶² The Court of Appeals for the Eighth Circuit in *Minnesota v. Heckler* (Pet., App. E) followed this Court's decision in *Schweiker v. Wilson* in rejecting the Department's application of the IMD exception to ICFs. Pet App. 18e. Other courts that have considered the IMD exclusion also have characterized it only in terms of mental hospitals, based on a reading of the legislative history. See, e.g., *Doe v. Colautti*, 592 F.2d 704, 709 (3d Cir. 1979) (referring to exclusion as relating to "inpatient care at a psychiatric hospital"); *Kantrowitz v. Weinberger*, 388 F. Supp. 1127, 1130 (D.D.C. 1974), aff'd, 530 F.2d 1034 (D.C. Cir.), cert. denied, 429 U.S. 819 (1976) (describing exclusion as relating to payments for inpatient care in mental hospitals); *Legion v. Richardson*, 354 F. Supp. 456, 459 (S.D.N.Y.), aff'd sub nom. *Legion v. Weinberger*, 414 U.S. 1058 (1973) (noting Congress' belief that care of the mentally ill "in state hospitals" was the responsibility of the states). The latter two decisions were cited by the court with approval in *Schweiker v. Wilson*, 450 U.S. at 237 n.19.

ill. The court's conclusion was heavily influenced by its failure to grasp the significant difference in Congressional attitude toward mental hospital care compared to care in other settings. See pages 54-55, supra, and Pet. App. 9a, 10a. From this starting point, the court dismissed the legislative evidence because of "the undeniable fact that Congress has never lifted the longstanding IMD exclusion for persons under age 65 or even indirectly implied such a purpose in the legislative history." Pet. App. 12a. Since Petitioner has never contended that Congress meant to lift the IMD exclusion for persons under 65, this "undeniable fact" does not advance the inquiry. Rather, it obscures the real question, which is what scope was intended initially for the IMD exception.

On this score, the court's opinion gave no weight to any of the expressions of intent or purpose by members of Congress or the responsible administering officials.⁶³ Neither did it advert to the court decisions pertaining to the IMD clause. Instead, it undertook its own review of Congressional hearings held after Medicaid was adopted, and based on certain statements of witnesses (other than members of Congress or administration spokesmen), concluded that the IMD provision was understood to cover all kinds of residential facilities, not just

⁶³ The court dismissed the significance of the Long Amendment, contending that the requirements for developing comprehensive mental health plans and alternatives to mental hospital care applied only with respect to the elderly. Pet. App. 11a-12a. This argument completely misses the point. The significance of the Long Amendment is that it expressly distinguished between IMDs on the one hand and nursing facilities on the other. (See pages 44-45, supra). This significance is unaffected by the court's argument.

hospitals.⁶⁴

This reliance on the least authoritative and most ambiguous kind of evidence of prior legislative intent to override the tide of contrary evidence described above yields the least dependable basis on which to predicate judgment. But beyond this, the court's analysis was misguided; the passages cited and other similar excerpts from the several-year hearing record confirm the well-expressed legislative intent to confine the IMD exception to mental hospitals.

In each of the three passages cited by the court below, the witness was seeking elimination of the IMD exclusion for persons under age 65, and in each case the witness stressed the desirability of

⁶⁴ The Department has never previously relied upon the excerpts on which the court pinned its decision.

obtaining Medicaid coverage for care of all persons in mental hospitals. The court cites the 1967 testimony of Dr. Robert W. Gibson on behalf of the American Psychiatric Association because he suggested that the IMD exclusion precluded Medicaid coverage not only in hospitals but also in a community mental health center. Pet. App. 12a.⁶⁵ The court omitted reference to two other witnesses in the same year who described the IMD exclusion (repeal of which they were seeking) as applying solely to mental

⁶⁵ Dr. Gibson's reference to community mental health centers was incorrect; the HEW report submitted a few years later showed the extent to which states did cover community mental health center services under Medicaid. Report, supra, at 37-38 (App. C). Medicaid coverage of these centers was not mandatory and, in 1967, when Medicaid was still in its infancy, there was little coverage of community mental health centers. Id.

hospitals.⁶⁶

The court below says that Congress never responded to the pleas of Dr. Gibson and others. But that conclusion is unwarranted. The outcome of the 1967 hearings was the law authorizing federal support for ICF care, which was defined to include care of people with mental conditions. So to the extent Dr. Gibson can be read as posing a problem for the care of the mentally ill in residential facilities other than mental hospitals,

⁶⁶ Social Security Amendments of 1967: Hearings on H.R. 12080 Before the Senate Comm. on Finance, 90th Cong., 1st Sess. 1748 (1967) (testimony of Dr. Leonard Ganser, National Association of State Mental Health Program Directors, who sought removal of "the exclusion against hospitals that specialize in treatment of mental illness"); Social Security Amendments of 1967: Hearings on H.R. 5710 Before the House Comm. on Ways and Means, 90th Cong., 1st Sess. 1665, 1675 (1967) (testimony of Dr. Charles L. Hudson, President of the American Medical Association, that the IMD exception excluded the "medically indigent patient ... under 65 ... [from] psychiatric treatment ... in a private or public mental hospital.>").

there was an immediate, direct and affirmative response.

The court below was quite confused about the significance of comments in the 1970 hearings, particularly those addressed to a provision that eventually was added as the last sentence of the definition of "intermediate care facility" when that category was added to Medicaid in 1971. As shown above (p. 33), that provision was confined to public institutions.⁶⁷ The question

⁶⁷ The submission of the Illinois Department of Public Aid crystallized the conceptual question that was raised by the provision as contained in the House bill:

"Where 'intermediate care' is all that is required but placement cannot be found in outside facilities, any public hospital for mental diseases is discouraged by the concluding paragraph of section 225 of the Bill ... from establishing a section in the institution to provide intermediate care. Federal aid is prohibited to patients in such a section of a public hospital." 1970 Senate Hgs. 1185 (emphasis added).

discussed in the 1970 hearing excerpts was whether public institutions for the mentally retarded should be brought under Medicaid (or whether it was already possible to do so). This debate had nothing to do with whether the IMD exclusion covers nursing homes. The real significance of the 1970 hearings is in the repeated references by Senator Long to IMDs as synonymous with mental hospitals. See 1970 Senate Hgs. 537, 539, 548, 939.

The court below deemed "most important" the testimony of state mental health directors Leopold and Gaver before the Senate Finance Committee in January 1972; yet the court misunderstood entirely the import of that testimony. The witnesses were pushing for elimination of the IMD exception for persons under age

65.⁶⁸ They urged "the principle of equity," not, as the court below thought' (Pet. App. 14a), to obtain coverage for the under-65 group in all settings, but rather so that "publicly administered facilities as well as private mental hospitals can receive payment ... on the same basis that general hospitals receive such benefits." 1971-72 Senate Hgs. 929.⁶⁹

Senator Long expressed sympathy for

⁶⁸ To support their position, the witnesses argued that the Long Amendment had been very successful for those 65 and over in mental hospitals, pointing to the substantial transfer of elderly patients from hospitals to other facilities, including SNFs and ICFs, even though federal funding had been made available for their hospital care. The court below erroneously construed this report of transfers to ICFs and SNFs as evidence that payment for care in those facilities was made possible only because of the IMD exception for the elderly. Pet. App. 14a.

⁶⁹ General hospital care for mental illness is covered under Medicaid. See note 29, page 42, *supra*.

the proposal, but suggested that it might not be acceptable unless there were strict standards imposed on the nature of the care to be provided in the mental hospitals. *Id.* at 929. Contrary to the discussion of this point by the court below, the failure to include nursing facilities in this suggestion merely confirms that Senator Long well understood the availability under existing law of Medicaid payments for under-65 mental cases in these kinds of facilities.⁷⁰

The record of hearings throughout the

⁷⁰ This understanding was expressed by Senator Long when he explained the legislation transferring the ICF provisions to Medicaid in 1971. See page 69, *supra*. The court below sought to avoid the impact of this explanation, saying that "it is wholly plausible to conclude" that the explanation referred only to care for the elderly. Pet. App. 15a. But Senator Long's statement was not so limited, and the court's only basis for engrafting such a limit on his comments was its erroneous understanding of the import of the hearings some weeks later that are discussed above.

period following enactment of Medicaid confirms the limited office of the IMD exclusion. The court below went awry because it built on implications, speculation and "plausible" inferences, none of which was found in the words it was analyzing, and on an erroneous initial premise that the IMD exception covered all types of residential facilities absent an explicit statutory limit on its scope. That premise assumed the very question to be answered. An objective view of the legislative evidence, approached without a predisposition either way, clearly reveals that the IMD exception was never meant to extend beyond mental hospitals to embrace alternative residential settings like intermediate care facilities.

III. THE CHALLENGED DISALLOWANCE ACTION UNDERMINES THE FEDERALISM CONCEPT ON WHICH THE PUBLIC ASSISTANCE PROGRAMS ARE BASED.

Even if it were less clear that the term "institution for mental diseases" does not embrace intermediate care facilities like Middletown Haven, the disallowance action would still be unwarranted. In this case, the disallowance is an after-the-fact withdrawal of federal financial support that was inconsistent with the premises on which Connecticut received the federal funds and paid for the needed services. As such, it conflicts with the constitutional predicate on which the Medicaid program rests.

A. The Disallowance Was Based on New and Uncertain Policies Not Implemented Until After the Federal Funds Were Received and Spent.

This is not a case where the Depart-

ment seeks return of federal matching funds upon discovery on audit that incorrect amounts were paid to the state, or that clearly established and specific conditions to payment were not satisfied.⁷¹ Rather, the disallowance is predicated on a legal interpretation never clearly enunciated to the states, and was dependent upon a subjective after-the-fact audit review that applied nonspecific criteria of doubtful validity.⁷²

The issue of applying the IMD exclusion to ICFs and SNFs surfaced in three

⁷¹ Cf. *Bell v. New Jersey*, 461 U.S. 773 (1983), where the only issue decided was the authority to recover incorrect payments.

⁷² The issue is thus "whether a State can be required to repay if ... the claim of violation rests on a new regulation or construction of the statute issued after the state entered the program and had its plan approved." *Bell v. New Jersey*, 461 U.S. at 793 (White, J. concurring).

internal memoranda to regional officials in 1975 and 1976, the last two of which reflect confusion and disagreement as to the new policy.⁷³ J.A. 5d-11d.⁷⁴ Little if anything was done by the Department to follow up on its new approach until late 1977, when it sought to clarify the "criteria" to be used in determining when SNFs and ICFs would be classified as IMDs. An October 1977 internal opinion by an Assistant Regional Attorney, apparently widely distributed among the regions and supplying the basis on which the subsequent audits were

⁷³ The internal memoranda apparently were issued after a General Accounting Office reviewer raised the question of applying the IMD exception to nursing homes. Comptroller General Report to the Congress: "Returning the Mentally Disabled to the Community: Government Needs to Do More" 90-91 (January 7, 1977).

⁷⁴ Connecticut became aware of the issue of the extension of the IMD exception to SNFs and ICFs in 1976. J.A. 3b.

conducted, identified eight relevant criteria. Pet. App. 27d-28d.

The opinion warned that some of the criteria "are more probative" than others, and admonished that "every indication of any significance that a given facility is primarily engaged in IMD activity should be marshalled to fulfill the regulatory mandate that the determination be on the basis of the facility's 'overall character'" Id. at 28d-29d (emphasis added).⁷⁵

The audit of Middletown Haven in December 1979 sought to apply these criteria. J.A. 2a-13a.⁷⁶ The audit team

⁷⁵ The references to "overall character" and "primarily engaged in IMD activity" are to the published regulations defining institutions for mental diseases. See page 8, *supra*.

⁷⁶ The audit team added two more criteria of its own: (1) the presence of staff specialized in the care of the mentally ill, and (2) results of
(footnote cont'd)

reviewed the records of every resident of Middletown Haven between January 1977 and September 1979, and concluded that well over half had mental disabilities. Based on this and the other criteria, it concluded that the overall character of Middletown Haven was that of an IMD. J.A. 24a.

The Department acknowledges that the states may not have had notice of all the criteria on which the various audits were based. Pet. App. 30d. But it says the criteria were never intended to be "criteria as such." Rather, they were "merely guidelines" in identifying possible IMDs, and no one of the criteria "was ever considered determinative with respect to the nature of the facility."

(footnote cont'd)
independent professional review by state review teams. J.A. 13a.

The criteria represented internal "clarification" of published regulations not intended "for the guidance of the public;" it was the regulations alone, according to the Department, that clearly placed states on notice of how the IMD exception would be applied. Pet. App. 30d-31d.⁷⁶

But the published regulations are manifestly inadequate to inform states of the Department's conception of the IMD exclusion. The content of the regulations relied upon by the Department has not changed significantly since it was first incorporated into the Handbook of Public Assistance Administration shortly after Medicaid was enacted. Yet when these provisions were adopted they could

⁷⁶ The regulation on which the Department relies, as it read at the time of the audit, is set forth in the Joint Appendix (J.A. 2e).

not have informed states about the Department's current interpretation. As shown, the Department then did not hold to that interpretation, and the Handbook expressly confined IMDs to mental hospitals. See pages 72-78, supra. Moreover, the regulation is far too vague to permit reasonable judgments as to its meaning, even if states had reason to believe that it could be applied to nursing facilities, as is evidenced by the Department's perceived need to develop implementing criteria.⁷⁸

The criteria would not have supplied the missing notice even if Connecticut had been apprised of them before certify-

⁷⁸ The circular statement of the Assistant Regional Attorney's memorandum of late 1977 that the ultimate aim of the regulation is to identify those facilities "primarily engaged in IMD activity" (Pet. App. 28d) highlights the absence of meaningful notice in the regulation.

ing Middletown Haven as a Medicaid provider, for they shed no light on the difficult issues inherent in identifying "mental disabilities," differentiating them from physical ailments, and determining when such a disability is the primary reason for the placement of the resident. See Pet. App. 34d, 36d-37d.⁷⁹

Contributing to the insufficiency of the criteria is the fact that they are inconsistent with the statutory purpose. In large part they rely, to justify classification as an IMD, on factors demonstrating the use of the facility as an alternative to mental hospital confinement. Yet, the statute expressly

⁷⁹ The fact that a reviewing agency determines later that the auditors' resolution of these difficult issues was reasonable (*id.*) does not make up for the absence of any basis for a state in advance to know with reasonable certainty what the governing standards for coverage are going to be.

describes and encourages the development of these "alternatives" for use in lieu of IMDs. 42 U.S.C. §1396a(a)(20) and (21).⁸⁰ The Eighth Circuit Court of Appeals concluded that the criteria were inconsistent with the statute, because they turn principally on the diagnosis of the residents of the facilities and thereby encroach on the evident statutory purpose of bringing Medicaid coverage to ICFs that care for people with mental diagnoses. Pet. App. 21e-22e.

The foregoing demonstrates that the

⁸⁰ The validity and effectiveness of the criteria have been questioned even by responsible officials within the Department. See Pet. App. 22e, n.25. And while the Department never sought public input before utilizing the criteria, in 1980 it requested public comment on what criteria should be used in classifying facilities as IMDs, including the possibility of a significant change in the percentage of residents with "mental disabilities" that would justify categorization as an IMD. 45 Fed. Reg. 47368, 47372 (1980). No further action has been taken.

approach utilized by the Department to implement its new interpretation of the IMD provision as applicable to SNFs and ICFs was flawed, and that Connecticut could not have known until the results of the December 1979 audit were obtained that expenditures made between January 1977 and September 1979 would be found ineligible for federal support by the Department. In every practical sense this was after-the-fact action -- an imposition of limitations that were not applicable or discernible during the period that Connecticut received and expended the federal funds in issue.

B. After-The-Fact Disallowances Are Impermissible Under the Public Assistance Titles of the Social Security Act.

The relationship of the states to the federal government under the public assistance provisions of the Social

Security Act is not that of regulated enterprise and regulator. Rather, the statute contemplates a joint endeavor between two sovereigns, with the states having the principal responsibility for carrying out the programs and for defining their scope within the limitations established by the federal statute. Funding is joint, and the quid pro quo for federal financial support is the willingness of states to conform their programs to the standards of the federal statute and regulations. This is the sense in which this Court has described these programs as exercises in "co-operative federalism." King v. Smith, 392 U.S. at 316; Harris v. McRae, 448 U.S. at 308.

The establishment of limits or standards applicable to state public assistance programs represents the

exercise of the federal spending power, for Congress may clearly "fix the terms on which it shall disburse federal money to the States." Pennhurst State School v. Halderman, 451 U.S. at 17. But unlike regulatory legislation, the relationship between federal and state governments under these titles is "in the nature of a contract." Id. In this context, the

"legitimacy of Congress' power to legislate under the spending power thus rests on whether the State voluntarily and knowingly accepts the terms of the 'contract.' ... There can ... be no knowing acceptance if a State is unaware of the conditions or is unable to ascertain what is expected of it. Accordingly, if Congress intends to impose a condition on the grant of federal moneys, it must do so unambiguously." Id.

These principles are transgressed by the attempt here to withdraw federal funds previously paid to Connecticut on the ground that Middletown Haven was an IMD. The exclusion now asserted by the

Department was certainly not unambiguously imposed by Congress. As shown, the IMD clause embodies a far more limited Congressional purpose. Moreover, the Department's method for implementing its broader interpretation of the IMD clause, including reliance on subjective and confusing criteria of dubious validity, wholly failed to provide the prior notice that must be the predicate for the "knowing acceptance" required by Pennhurst for limits applicable to the grant of federal financial support. Cf. Commonwealth of Kentucky, Department of Education v. Secretary of Education, 717 F.2d 943 (6th Cir. 1983), cert. granted, 83 L.Ed.2d 26 (1984).

Public assistance in general, and Medicaid in particular, are among the largest categories of expenditures made

by states.¹¹ Further, Medicaid is bewildering in its complexity. It affords states scores of options for coverage and scope of services, each of which can have major budgetary implications.

If states elect to participate in the Medicaid program and receive the accompanying federal funds, only to find later that new limitations will be imposed after the fact, creating a large repayment burden that must be satisfied out of current funds, the impact on state treasuries and prudent fiscal management will be disastrous.¹²

¹¹ In 1983 states (and local governments) spent almost \$16 billion of their funds for Medicaid (DHHS Press Release, October 10, 1984), and an additional \$6 billion for AFDC (Budget of the United States Government FY 1985, Appendix at I-K33).

¹² The importance to states of certainty in
(footnote cont'd)

The adverse affects of after-the-fact disallowances are not just budgetary and financial. The needy people served are also affected. No state can responsibly ignore federal attempts to disallow funds, even if not justified, and where states do respond by cutting back the challenged activity it is the needy recipients who will suffer most.¹³

(footnote cont'd)

federal standards and reliability of federal commitments is reflected in the Act. It explains why Congress provided for advance payment of the federal share, based on estimates, so that states would not have to finance the entire cost of covered services and rely solely on the promise of future reimbursement. See 42 U.S.C. §§603(b), 1396b(d). It also explains the provision that any sanction for state violation of its plan or of federal requirements be prospective only, and imposed only if the state fails to bring its operations into compliance. See 42 U.S.C. §§604, 1396c.

¹³ Connecticut ceased claiming federal support for Middletown Haven after receipt of the disallowance in this case. See note 5, page 11, supra. Discharges from state mental hospitals to this and other nursing facilities were suspended after federal officials first raised the IMD issue in mid-1979. J.A. 7a.

These are some of the considerations that underlie the spending power standards enunciated in Pennhurst, which standards are not met by the Department's effort after the fact to disallow federal support for ICF services at Middletown Haven.

IV. DEFERENCE TO THE DHHS INTERPRETATION OF THE IMD EXCEPTION IS NOT JUSTIFIED.

A. The Department's Position Does Not Merit Deference Under the Applicable Precedents.

This Court has never accorded blind deference to administrative interpretations of Acts of Congress. As the Court reminded again just last Term:

"Judicial deference to an agency's interpretation of a statute 'only sets the framework for judicial analysis; it does not displace it.'" ... United States v. Cartwright, 411 U.S. 546, 550 (1973).... A reviewing court 'must reject administrative constructions of [a] statute, whether reached by adjudication or by rulemaking, that are inconsistent with the statutory

mandate or that frustrate the policy that Congress sought to implement.' Federal Election Comm'n v. Democratic Senatorial Campaign Comm., 454 U.S. 27, 32 (1981)." Security Industry Association v. Board of Governors 82 L.Ed.2d 107, 113 (1984).

This refusal to "rubber-stamp" administrative decisions that are "inconsistent with a statutory mandate or that frustrate the congressional policy underlying a statute" has been repeatedly emphasized. NLRB v. Brown, 380 U.S. 278, 291 (1965); Volkswagenwerk Aktiengesellschaft v. FMC, 390 U.S. 261, 272 (1968); SEC v. Sloan, 436 U.S. 103, 118 (1978); Federal Election Commission v. Democratic Senatorial Campaign Committee, 454 U.S. 27, 32 (1981).

Throughout this controversy, the Department has argued that its interpretation of the term "institution for mental diseases" should be upheld, and the disallowance sustained, based on the

deference that should be accorded an agency in the interpretation of statutes that it is responsible for implementing. No such deference is warranted here, because the Department's interpretation of the IMD exception does not comport with the terms, meaning or purpose of the Medicaid statute.

Even if the conflict between the statute and the current administrative interpretation were less clear, there would still be no warrant for the deference claimed by DHHS. This is not a case where the administrative construction has been clearly and consistently applied from the time the statute was first enacted. Compare Saxbe v. Bustos, 419 U.S. 65, 73-74 (1974). In the important early years of Medicaid, the Department viewed the IMD exception as limited to mental hospital settings. See pages

72-78, supra. When the Department did alter its official interpretation, it did so through internal memoranda, it let years pass before implementing its new view, and it provided states no means for sensibly predicting how the new interpretation would be applied. These factors all diminish any deference that the Department's interpretation might otherwise command. See Security Industry Association v. Board of Governors, 82 L. Ed. 2d at 114; Batterton v. Francis, 432 U.S. 416, 424-26 and n.9 (1977).¹⁴

Finally, the federalism interests involved, and particularly the powerful rationale for insisting on clarity in the terms of the governmental compact and

¹⁴ Also pertinent is the absence in the statute of a particular delegation of authority to the Department to interpret the IMD exclusion. Compare Herweg v. Ray, 455 U.S. 265, 274-75 (1982); Schweiker v. Gray Panthers, 453 U.S. at 43-44.

resisting after-the-fact imposition of conditions, militate against giving deference to the views of the Department, particularly when both partners are equally capable of understanding and construing the statutory terms.

B. The Department's Interpretation Is Premised on Policy Grounds That Are In Conflict With the Policy Adopted By Congress.

There are additional reasons for refusing deference to the Department's views. The express motivation for the Department's interpretation of the IMD exclusion as encompassing SNFs and ICFs is to respond to the transfer of patients from mental hospitals to nursing facilities. Pet. App. 15d.⁸⁵ The first of the

⁸⁵ This concern about transfer of patients from mental hospitals into nursing homes seems to have been a prime impetus for the audit in Connecticut that resulted in the present disallowance. The audit report refers to "recent indications that

(footnote cont'd)

internal memoranda that enunciated the Department's broadened view of the IMD exclusion stated that any facilities that concentrate "on managing patients with behavior or functional disorders and are used largely as an alternative care facility for mental hospitals" must be classified as IMDs. J.A. 2d.⁸⁶

The notion that use of a nursing facility as an alternative to a mental hospital makes that facility an IMD is in square conflict with the statute and its underlying purposes, as shown above.

(footnote cont'd)
the State of Connecticut has been discharging large numbers of mentally ill patients from State mental institutions into skilled nursing facilities (SNF's) and intermediate care facilities (ICF's)" that caused the Regional Medicaid Director to undertake the investigation. J.A. 6a.

⁸⁶ The initial memorandum further asserted that any facility "frequently or predominantly used for individuals who are either discharged from mental hospitals or would otherwise be admitted to them are almost certainly in this [IMD] category" J.A. 2d.

Any suggestion that nursing facilities must be classified as IMDs to prevent inappropriate transfer of patients from mental hospitals (where Medicaid support is concededly unavailable for persons between the ages of 21 and 65) would also be contrary to Congressional policy. This is best evidenced by the provision of the Long Amendment that enjoins states adopting policies of moving patients out of mental hospitals and into other settings to provide "assurance of immediate readmittance to institutions where needed for individuals under alternate plans of care." 42 U.S.C. §1396a(a)(20).⁸⁷

Enforcement of the obligation to readmit patients to the mental hospital is

⁸⁷ The committee reports stressed the importance of this provision because "not always does a discharge plan work out to the best advantage of the patient." 1965 S. Rep. 145; 1965 H. Rep. 127-28.

furthered by the requirement of periodic professional review of the placement of and services furnished to residents of SNFs and ICFs. 42 U.S.C. §1396a(a)(26) and (33).

As these various statutory provisions demonstrate, Congress resolved the problem of "inappropriate" transfer of patients from mental hospitals to other facilities by providing for individualized periodic review of each recipient's situation and assurance of return to the hospital where needed, not by a blanket prohibition of Medicaid coverage for the alternate care facility that the Department opted for in its subsequent interpretation.⁸⁸

⁸⁸ Middletown Haven did not serve severe mental cases -- those with diagnoses of "acute mental disorder" (J.A. 43a), and a substantial number of residents that were admitted from state mental (footnote cont'd)

When Congress has chosen a particular approach to the resolution of an issue, deference is not afforded to an administrative interpretation that incorporates a different, inconsistent approach.

Security Industry Association v. Board of Governors, 82 L.Ed. 2d at 120.**

The Department's policy interpretation conflicts with Congressional policy in other respects as well. The DHHS approach, of disqualifying a facility based on the mental diagnoses of a majority of the residents, conflicts with the statu-

(footnote cont'd)

hospitals were returned to the hospitals for further treatment. J.A. 17a-18a.

** There is no evidence that the individualized policy selected by Congress has not worked, and ample evidence that it has succeeded. See 1971-72 Senate Hgs. 925-28. The mere fact of significant numbers of transfers from mental hospitals to alternative facilities does not, contrary to the Department's apparent approach, reveal a problem. That is exactly the result hoped for by the Joint Commission, and by the Congress when it adopted the Long Amendment.

tory policy against discrimination in the administration of the Medicaid program on the basis of diagnosis, a policy that finds specific expression in the regulations. See 42 U.S.C. §1396a(a)(10) and 42 C.F.R. §440.230(c) (1983).⁹⁰ The Department's position also has the effect of denying federal support to residents of nursing facilities who are not afflicted with mental disorders, if they happen to be residing in a facility that is categorized as an IMD based on the Department's view of its "overall

⁹⁰ The Eighth Circuit Court pointed to this unwanted feature in rejecting the Department's position. Pet. App. 21e. That court also found this feature to be inconsistent with the prohibition on discrimination on the basis of handicap, proscribed by the Rehabilitation Act of 1973, 29 U.S.C. §794, noting that "handicap" has been defined to include any mental disorder. 45 C.F.R. §§84.3(j), 84.4(b) (1983). See Pet. App. 21e, n.23.

character."⁹¹ And for all people under age 65, the Department's position is at odds with the goal of the Joint Commission and the Long Amendment of reducing reliance on large mental hospitals.

A policy interpretation with these characteristics commands neither support nor sympathy, and since it is not compelled by clear and specific statutory terms, the regressive policy consequences provide still further reason not to accord any deference to it.

CONCLUSION

For all of the foregoing reasons, Petitioner respectfully requests that the Court reverse the judgment of the Court

⁹¹ The position has the further consequence that children may receive Medicaid support for care in expensive psychiatric hospitals (see note 36, page 48, supra) but not if their conditions are susceptible to treatment in less expensive alternative facilities that the Department decides are IMDs.

of Appeals and remand the case with instructions to have the disallowance in issue set aside, so that the federal Medicaid funds previously paid to support the services provided in Middletown Haven will be restored to the State of Connecticut.

Respectfully submitted,

CHARLES A. MILLER*
MICHAEL A. ROTH
ROBIN J. ARMBRUSTER
Covington & Burling
1201 Pennsylvania Avenue, N.W.
P.O. Box 7566
Washington, D.C. 20044
(202) 662-6000

JOSEPH I. LIEBERMAN
Attorney General
30 Trinity Street
Hartford, Connecticut 06106

DONALD M. LONGLEY
Assistant Attorney General
90 Brainard Road
Hartford, Connecticut 06114

Attorneys for Petitioner State
of Connecticut, Department of
Income Maintenance

January 1985

*Counsel of Record

APPENDIX

APPENDIX A

FULL TEXT OF STATUTORY PROVISIONS INVOLVED

The following are provisions of the Social Security Act, Title XIX (Grants to States for Medical Assistance Programs), Pub. L. No. 89-97, § 121, 79 Stat. 343-353 (1965) (as amended) applicable to this controversy:

1. Section 1905(a) of the Act, 42 U.S.C. § 1396d(a)(1), (4)(A), (14), (15) and (18)(B), as amended, provides in relevant part:

"(a) The term 'medical assistance' means payment of part or all of the cost of the following care and services . . .

"(1) inpatient hospital services (other than services in an institution for tuberculosis or mental diseases);

* * *

"(4)(A) skilled nursing facility services (other than services in an institution for tuberculosis or mental

diseases) for individuals 21 years of age or older; . . .

* * *

"(14) inpatient hospital services, skilled nursing facility services, and intermediate care facility services for individuals 65 years of age or over in an institution for tuberculosis or mental diseases;

"(15) intermediate care facility services (other than such services in an institution for tuberculosis or mental diseases) for individuals who are determined . . . to be in need of such care;

* * *

"(18) . . .; except as otherwise provided in paragraph (16), such term does not include . . . (B) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for tuberculosis or mental diseases."

2. Section 1905(c) of the Act, 42

U.S.C. § 1396d(c), as amended, provides in pertinent part:

"(c) For purposes of this subchapter the term 'intermediate care facility' means an institution which (1) is licensed under State law to provide, on a regular basis, health-related

care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities The term 'intermediate care facility' also includes any skilled nursing facility or hospital which meets the requirements of the preceding sentence. . . . With respect to services furnished to individuals under age 65, the term 'intermediate care facility' shall not include, except as provided in subsection (d) of this section, any public institution or distinct part thereof for mental diseases or mental defects."¹

3. Section 1902(a) of the Act, 42

U.S.C. § 1396a(20) and (21), provides in relevant part:

"A State plan for medical assistance must --

* * *

¹ The provisions with respect to intermediate care facilities were added by section 4(a) of the Social Security Amendments of 1971, Pub. L. No. 92-223, 85 Stat. 809.

"(20) if the State plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in institutions for mental diseases --

"(A) provide for having in effect such agreements or other arrangements with State authorities concerned with mental diseases, and, where appropriate, with such institutions, as may be necessary for carrying out the State plan, including arrangements for joint planning and for development of alternate methods of care, arrangements providing assurance of immediate readmittance to institutions where needed for individuals under alternate plans of care, and arrangements providing for access to patients and facilities, for furnishing information, and for making reports;

"(B) provide for an individual plan for each such patient to assure that the institutional care provided to him is in his best interests, including, to that end, assurances that there will be initial and periodic review of his medical and other needs, that he will be given appropriate medical treatment within the institution, and that there will be a periodical determination of his need for continued treatment in the institution; and

"(C) provide for the development of alternate plans of care, making maximum utilization of available resources, for recipients 65 years of age or older who would otherwise need care in such institutions, including appropriate medical treatment and other aid or assistance; for services referred to in section 303(a)(4)(A)(i) and (ii) of this title, section 803(a)(1)(A)(i) and (ii) of this title, or section 1383(a)(4)(A)(i) and (ii) of this title which are appropriate for such recipients and for such patients; and for methods of administration necessary to assure that the responsibilities of the State agency under the State plan with respect to such recipients and such patients will be effectively carried out;

"(21) if the State plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in public institutions for mental diseases, show that the State is making satisfactory progress toward developing and implementing a comprehensive mental health program, including provision for utilization of community mental health centers, nursing facilities, and other alternatives to care in public institutions for mental diseases;"

APPENDIX B

Excerpts from S.Rep. No. 404, Pt. I,
89th Cong., 1st Sess. (1965)

[p. 20]

2. Tubercular and Mental Patients

The House bill removed the exclusion from Federal matching in old-age assistance and medical assistance for the aged programs (and for combined program, title XVI) as to aged individuals who are patients in institutions for tuberculosis or mental diseases or who have been diagnosed as having tuberculosis or psychosis and, as a result, are patients in a medical institution. The House bill requires as a condition of Federal participation in such payments to, or for, patients in mental and tuberculosis hospitals certain agreements and arrangements to assure that better care results from the additional Federal money. The committee has amended this provision so as to make the special provisions for Federal participation applicable solely to payments for the aged persons in mental institutions. The States will receive additional Federal funds under this provision only to the extent they increase their expenditures for mental health purposes under public health and public welfare programs. The bill also removes restrictions as to Federal matching for needy blind and disabled who are tubercular or psychotic and are in general medical institutions.

Effective January 1, 1966. Cost:
About \$75 million a year.

* * *

[pp. 144-47]

2. REMOVAL OF LIMITATIONS ON FEDERAL PARTICIPATION IN ASSISTANCE TO AGED INDIVIDUALS WITH TUBERCULOSIS OR MENTAL DISEASES

Since the enactment of the Social Security Act, patients in public mental and tuberculosis hospitals have not been eligible under the public assistance titles of the Social Security Act, and only prior to 1951 were individuals eligible who were patients in private mental and tuberculosis hospitals. The reason for this exclusion was that long-term care in such hospitals had traditionally been accepted as a responsibility of the States.

There have been many encouraging developments, in the meantime, in the care and treatment of the mentally ill and tuberculous. Most significantly progress is being made in the provision of short-term therapy in the patient's own home, in special sections of general hospitals, in specialized mental hospitals, and in community mental health centers. This latter type of facility is being particularly encouraged by Federal help under the Community Mental Health Centers Act of 1963.

For these reasons in reporting the social security bill (H.R. 11865) last

year, the committee added a provision, similar to the provision in this year's bill, which removes the distinction hitherto maintained in the public assistance titles of the Social Security Act -- between the aged who are ill with a diagnosis of psychosis or tuberculosis and the aged with other diagnosed illnesses.

Under the provisions of the committee bill, Federal financial participation would become available effective January 1, 1966, in assistance (money payments, if appropriate, or payment for medical care) for aged persons otherwise eligible under State plans for OAA, MAA, or under the combined programs for the aged, blind or disabled (title XVI) who: (1) are patients in hospitals for mental diseases or for tuberculosis or (2) are patients in general hospitals without regard to the length of their stay, and are there because of a diagnosis of psychosis or tuberculosis. Federal financial participation would also become available for assistance under titles X, XIV, and XVI of the Social Security Act for blind or disabled persons of any age who are in a general hospital with a diagnosis of psychosis or tuberculosis.

Since the provisions of the bill are designed to improve the care provided by States and to assure that Federal participation is used for such improvement, it is not intended that the availability of care for the mentally ill or tubercular under other State or local programs be considered a resource in determining the

eligibility of patients for public assistance with Federal participation in the payments made.

The House bill incorporated special standards of care for mental and tuberculous patients. The Department of Health, Education, and Welfare has informed the committee that the number of aged tuberculous patients is so small that, with present methods of treatment, special safeguards are not necessary for this group. A committee amendment would accordingly leave the safeguards fully applicable to the mentally ill but would eliminate the special requirements for treatment of aged persons with tuberculosis who are in specialized institutions. A description of the safeguards follows:

For those States that wish to take advantage of Federal participation in payments to the mentally ill who are in institutions for mental disease, the bill requires a provision for a joint agreement or other arrangement between the units of State or (where appropriate) local governments, and where appropriate with institutions for mental diseases. This agreement is not only intended to set forth the way of work between the agencies administering welfare and health programs, but also to set forth alternative methods of care, particularly for the aged who are mentally ill. Institutional treatment and care in the individual's own home are only two of the possible ways of caring for the aged who have mental problems. It is expected that the joint agreements will include

plans for the use of other methods of care, such as nursing homes, short-term care in general hospitals, foster family care, and others. This legislation, it is anticipated, will give further encouragement to the trend in the States for discharging from mental hospitals to the community the aged who are considered able to care for themselves, under some form of protective arrangements. The committee is aware that not always does a discharge plan work out to the best advantage of the patient, and thus the committee's bill provides that the agreement must make provision for the prompt readmittance to the institution where needed for the aged person who had been placed under an alternate plan of care. Inasmuch as the public welfare agency will be responsible for the determination of eligibility under the State plan for all applicants for assistance in the hospital, it is important that representatives of the agency have free access to the patient in the hospital. It is equally important that the hospital give to the public welfare agency the information it needs to administer its part of the program including the provision of assistance and the related social services. Under the committee bill, the agreement must include these arrangements.

A second safeguard, under the committee's bill, is a provision that the State plan include a provision for an individual plan for each patient in the mental hospital to assure that the care provided to him is in his best interests and that there will be initial and periodic review

of his medical and other needs. The committee is particularly concerned that the patient receive care and treatment designed to meet his particular needs. Thus, under the committee bill, the State plan would also need to assure that the medical care needed by the patient will be provided him and that other needs considered essential will be met and that there will be periodic redetermination of the need for the individual to be in the hospital.

The committee bill provides for the development in the State of alternative methods of care and requires that the maximum use be made of the existing resources in the community which offer ways of caring for the mentally ill who are not in hospitals. This is intended to include provision for persons who no longer need care in hospitals and who can, with financial help and social services to the extent needed, make their way in the community. Under the 1962 Public Welfare Amendments, State public welfare agencies are encouraged to provide social services for the aged and additional Federal financing is available to assist in the cost. Under the committee bill, these social services would be made available, as appropriate, for the aged who are in the hospitals or who would otherwise need care in an institution.

The committee believes that responsibility for the treatment of persons in mental hospitals -- whether or not they be assistance recipients -- is that of the mental health agency of the State. Social services may be needed for members

of the patient's family, and this responsibility can be carried by the local welfare agency with Federal financial help. When the patient leaves the mental hospital to receive one of the alternative methods of care, followup social services are usually essential if the discharge plan is to be successful. Such services can be given by the public welfare agency or (if provided in the agreement between the two agencies referred to earlier) could be given by the staff of the hospital. Social services to the aged who have mental health problems, the committee believes, are important as a means of preventing further deterioration and avoiding or delaying admittance or readmittance to the institution.

The committee recognizes that the administration of these provisions will place new responsibilities upon the welfare agencies and if these responsibilities are to be carried out effectively, appropriate planning and execution will be required. Thus the committee's bill provides authority for the Secretary to establish necessary methods of administration for the States in carrying out these provisions.

Under the bill, the Federal Government will be participating in the costs of care given to the needy aged in certain institutions. In order to assure that the rates for the care of recipients who are patients in such institutions are reasonable, the bill provides that the State must have suitable methods for the determination of the cost. The committee expects that this determination will be

made without imposing burdensome fiscal methods on the States.

The committee believes it is important that States move ahead promptly to develop comprehensive mental health plans as contemplated in the Community Mental Health Centers Act of 1963. In order to make certain that the planning required by the committee's bill will become a part of the overall State mental health planning under the Community Mental Health Centers Act of 1963, the committee's bill makes the approvability of a State's plan for assistance for aged individuals in mental hospitals dependent upon a showing of satisfactory progress toward developing and implementing a comprehensive mental health program -- including utilization of community mental health centers, nursing homes, and other alternative forms of care.

The committee wishes to insure that the additional Federal funds to be made available to the States under the provisions of the bill will assist the overall improvement of mental health services in the State. State and local funds now being used for institutional care of the aged will be released as a result of the bill, but there is great need for increased professional services in hospitals and for development of alternate methods of care outside the hospitals. To accomplish this, States may have to reallocate their expenditures for mental health to promote new methods of treatment and care. The committee bill provides that the States will receive additional Federal funds only to the extent

that a showing is made to the satisfaction of the Secretary that total expenditures of the States or its political subdivisions from their own funds for mental health services are increased. Such expenditures may be financed under State or local public health or public welfare programs. Expenditures will be measured against a base period and will include comparable items of expenditure for mental health programs by States and local public health and welfare agencies, including expenditures for payments to or in behalf of public assistance recipients with mental health problems and expenditures for services and other administrative items under health and welfare programs.

APPENDIX C

Excerpts from Department of Health,
Education, and Welfare, SSA,
Office of Research and Statistics:
Financing Mental Health Care Under
Medicare and Medicaid
(Research Report No. 37) (1971)

[pp. 36-38]

OTHER ISSUES

COMPREHENSIVE MENTAL HEALTH SERVICES

Medicaid provides Federal financial support for most psychiatric services for eligible persons of all ages, except in the case of the specific statutory exclusion of payment for care of patients under the age of 65 in mental institutions. Services important in the treatment of the mentally ill covered under Medicaid are:

(a) Inpatient hospital services -- hospitalization in psychiatric wards of general hospitals.

(b) Outpatient hospital services -- treatment in mental hygiene outpatient clinics, including community health centers, operated by qualified general and psychiatric hospitals.

(c) Physicians' services -- diagnosis, evaluation, and treatment by psychiatrists.

(d) Skilled nursing home services -- a required service for needy persons over age 21; optional for those under age 21.

(e) Other laboratory and X-ray services.

(f) Clinic services -- currently an optional service adopted by 30 States and the District of Columbia; these would include "free standing" mental hygiene clinics and community mental health centers.

(g) Prescribed drugs -- currently a State option covering medications such as psychotropic drugs.

The first five services listed are required by law for the categorically needy in a State Title XIX plan.

Although the above services are available under Medicaid for treatment of the mentally ill, administrative restrictions on services may be and have been set by the States, for example, limiting inpatient hospital care to 21 days. States are not permitted, under Title XIX, to differentiate or exclude services to persons on the basis of diagnosis; nevertheless, they may limit the amount of services provided, e.g., limiting physicians' services to one visit per month. In fact, HEW staff have observed during field visits that some States, in practice, limit psychiatric services even more than specified in their Title XIX plans. For example, States are expected to publicize eligibility requirements and

services available under Medicaid, yet this has been done on a limited scale only in some States; a number of States also restrict the amount of payments made for hospital outpatient treatment for the mentally ill, or for their treatment in general hospitals; and with the exception of a few of the larger States, utilization of the Medicaid program for community mental health services has been minimal.**

In regard to psychiatric clinic services under Medicaid, coverage may occur under the following conditions:

(a) If a clinic is part of an accredited general or psychiatric hospital, it is classified as providing outpatient hospital services, and coverage is required for the categorically needy under the law.

(b) If a clinic is not part of an accredited hospital, it may be covered

** Publicity within a broad State educational and information program under Medicaid, is recommended as a requirement in the Report of the Task Force on Medicaid and Related Programs, op. cit., p. 74. However, the Task Force recommendation is broadly written, without specific reference to mental health programs. Unless this emphasis is reflected in such a requirement, it is probable that those jurisdictions which, in the past, have not encouraged utilization of mental health services will continue to understress this area in the future.

under clinical services which are currently optional under Medicaid.

There are no national data on utilization by the States of Title XIX funds for support of the community mental health services, although it is known that only 30 States and the District of Columbia have taken advantage of the option to provide clinic services, as indicated in table 27. The potential for use of community mental health services as an alternative to hospital inpatient care is suggested by the experience of one State where Medicaid payments for persons under treatment in community mental health centers have accounted for 5 to 60 percent of the income of individual centers in the State. Indeed, the Task Force on Medicaid and Related Programs recognized the general need for broadening the availability of services in State Medicaid programs, recommending that:

Innovative facilities for provision of medical care (e.g., neighborhood health centers, community health centers, group practices, outpatient services of hospitals which provide neighborhood, comprehensive ambulatory care and other facilities) should be included as eligible vendors which recipients under Title XIX may elect and be encouraged to use, assuming appropriate standards of health care are met.⁴⁵

⁴⁵ Ibid., page 22.

However, a comprehensive program of services for the mentally ill, with emphasis on ambulatory care, at present is not a requirement under Medicaid, and is not included in the Medicaid plans of a number of States.

[pp. 39-40]

INPATIENT CARE IN PSYCHIATRIC HOSPITALS

Federal sharing with the States is available for the cost of most types of care for the mentally ill because Title XIX prohibits elimination of patients from the program on the basis of diagnosis.

In regard to those 65 years and over, data for fiscal years 1966, 1967, and 1968 on resident population and first admissions in public mental hospitals for the Nation and for the 10 States with the largest number of Medicaid patients in 1968, are given in table 30. The rate of resident aged patients in the country as a whole declined some 14 percent between 1966-68, and 8 percent in the first admissions during this interval. Seven of the States show a consistently higher rate of resident aged patients than the national average; 5 States had a higher rate of first admission. Of the 10 States cited, 8 had reduced rates of resident patients in 1966-67; all 10 States experienced such a decline in 1967-68. Rate of first admissions, however, although manifesting a similar trend in 1966-67, increased substantially

during 1967-68 in Massachusetts, Maryland, and New York.

The extent to which the availability of medical assistance payments has influenced the general drop in the number of resident patients and first admissions in public mental hospitals is not clear. Reports from States do indicate, however, the following gains resulting from Medicaid vendor payments and related requirements:

- (a) increased medical treatment, surgical procedures, and prosthetic devices available to patients;
- (b) increased use of alternatives to psychiatric hospitals;
- (c) opportunities for patients to have comfort items, to purchase clothing for selves, etc., as a result of assistance payment allowances;
- (d) increased use of social services, activities, and ward personnel; and
- (e) more consistent checking of patient status and therapeutic needs.

AGE RESTRICTIONS ON INPATIENT CARE

As already noted, a major benefit of Medicaid is coverage of eligible persons aged 65 and over for inpatient care in psychiatric institutions. But, it is clear that a major limitation of Title XIX is the exclusion of persons under age 65, from like inpatient services in a

psychiatric institution. There are, indeed, two major exclusions:

- (1) inpatient hospital services for mental diseases are prohibited for all persons under age 65; and
- (2) skilled nursing home services for mental diseases are prohibited for all persons under age 65.

It may be noted that adults aged 18-64, in order to be eligible for inpatient care in psychiatric institutions under Title XIX, would have to meet State definitions of permanent and total disability. The definition of permanent and total disability varies considerably among the States. Taking these factors into consideration, a rough estimate of the daily census of adults under age 65 in mental hospitals who might be covered under Medicaid at present in the category of permanent and total disability, is 75,000; an additional smaller number probably could also qualify under the Aid to the Blind program. Dr. Leonard Ganer, a psychiatrist speaking for the National Association of State Mental Health Program Directors, in 1967, estimated a total of some 253,000 persons under age 65 would become eligible for benefits under Title XIX if they were hospitalized in a mental hospital, should the present age limitation be removed.**

** Hearings Before the Committee on Finance, U.S. Senate, 89th Congress, op. cit., Part 3, p. 1745.

As noted previously, the National Institute of Mental Health has projected resident populations in mental hospitals by age from 1967 through 1973. The expected changes by 1973 are summarized in chart 5. Most striking is the substantial decline in hospital patients anticipated at every age group except under 25 years, which shows an increase of 7 percent. Indeed, rates of admission to public mental hospitals of young people have shown an alarming increase over the years despite the development of community resources. There can be little doubt that a large percentage of the 34,376 young people expected to be in public mental hospitals by 1973 would be eligible for assistance from the Medicaid program if the present age restriction were lifted.

No data are available on the likely cost to the Federal government if inpatient psychiatric treatment was included in Medicaid benefits to persons 18-64 years old. In this regard, however, psychiatric experts consulted by DHEW staff stressed two factors:

- (1) The age restriction in Title XIX excluded people in age groups most likely to benefit from active treatment in the psychiatric hospital.

- (2) Such treatment made available under Medicaid would contribute to the rehabilitation of young and middle-aged adults and facilitate their return to the community as economically productive and useful members of society.

[pp. 47, 48-49]

Appendix 1

LEGISLATIVE HISTORY OF FEDERAL FINANCING OF PSYCHIATRIC SERVICES

* * *

B. MEDICAID--TITLE XIX OF THE SOCIAL SECURITY ACT

Under the original Social Security Act in 1935, patients in public mental and tuberculosis hospitals and inmates of State institutions or the mentally retarded were not eligible for public assistance because care of the mentally ill traditionally was considered a responsibility of the States. And in 1950, when Federal financial participation became available for medical care of public assistance recipients, the decision was made not to include patients in mental hospitals, because the legislators felt the best way to get assistance to the States in this area was via a broad grant program, not through aid to the individual. This change also prohibited the use of Federal funds for care of patients in general hospitals with a diagnosis of psychotic condition, which prevented States from transferring mental patients to general hospitals just to get Federal money.

But in 1960, the long-held policy of prohibiting Federal financial assistance

for the care of patients in mental hospitals began to relax partly because of the recognition that new treatment methods made possible the care of mental patients on a short-term basis.

In 1960, Senator Russell Long first introduced an amendment to permit Federal matching of vendor payment under Title I (Old Age Assistance) for public mental hospitals. While this particular measure failed to pass, medical payments for aged persons with a psychiatric diagnosis were permitted for up to 42 days when such persons were being treated in general hospitals.

In June of 1962, the Department of Health, Education and Welfare's Bureau of Family Services changed its policy regarding public assistance payments to patients on convalescent leave from mental hospitals to permit States to obtain matching Federal funds in this area. Any State that wished to take advantage of such Federal matching funds was required to make provisions for an agreement between its public assistance agency and the agency responsible for institutional care of the mentally ill.¹

Provisions similar to those introduced by Senator Long in 1960 were incorporated in the 1964 Social Security bill (H.R. 11865). Although this bill too failed to

¹ This was a direct forerunner of the provision for such written agreements found in the 1965 Welfare Amendments to the Social Security Act.

pass, the so-called "Long Amendments" were included in the Social Security bill of 1965, ultimately passed as P.L. 89-97--the Social Security Amendments of 1965. This established, in addition to Title XVIII (Medicare) discussed earlier, Title XIX (Medicaid) of the Social Security Act, which contained medical assistance to aged individuals, including coverage for those patients in institutions for the treatment of mental diseases who meet State standards of financial need.

The mental health provisions of Title XIX made Federal financial participation available, effective January 1, 1966, for persons aged 65 and over who were eligible for Old Age Assistance or Medical Assistance to the Aged, or under the combined adult assistance programs (Title XVI). Included were the elderly in hospitals for mental diseases (or for tuberculosis) or in general hospitals because of such diagnosis, regardless of their length of stay. Title XIX also removed the earlier 42-day limitation, and provided for Federal assistance to eligible persons of any age under OAA, MAA, AFDC, AB, and APTD who were hospitalized for mental illness in general hospitals.²

² OAA - Old-Age Assistance
MAA - Medical Assistance to the Aged
AFDC - Aid to Families with Dependent Children
AB - Aid to the Blind
APTD - Aid to the Permanently and Totally Disabled

The Long Amendment is a companion piece to the Title XVIII legislation that makes Federal assistance available for eligible aged persons in mental institutions, when Medicare benefits have been exhausted.

No. 83-2136

FILED

JAN 2 1985

ALEXANDER L. STEVENS
CLERK

IN THE
Supreme Court of the United States

OCTOBER TERM, 1984

STATE OF CONNECTICUT,
DEPARTMENT OF INCOME MAINTENANCE,

Petitioner,

v.

MARGARET M. HECKLER, SECRETARY,
and THE UNITED STATES DEPARTMENT OF
HEALTH AND HUMAN SERVICES,

Respondents.

**BRIEF OF AMICI CURIAE THE STATES
OF ILLINOIS, CALIFORNIA, AND MINNESOTA
ON BEHALF OF THE PETITIONER**

NEIL F. HARTIGAN
Attorney General of Illinois

JILL WINE-BANKS
Solicitor General of Illinois

JAMES C. O'CONNELL *

BARBARA L. GREENSPAN
Special Assistant Attorneys General
130 North Franklin Street, Suite 300
Chicago, Illinois 60606
(312) 793-2380

ATTORNEYS FOR AMICUS CURIAE,
STATE OF ILLINOIS

* Counsel of Record

(Additional Attorneys General listed on inside front cover)

JOHN K. VAN DE KAMP
Attorney General of California

THOMAS E. WARRINER
Assistant Attorney General

ELISABETH C. BRANDT
Deputy Attorney General
1515 K Street, Suite 511
Sacramento, California 95814
(916) 324-5365

**ATTORNEYS FOR AMICUS CURIAE,
STATE OF CALIFORNIA**

HUBERT H. HUMPHREY III
Attorney General of Minnesota

BEVERLY JONES HEYDINGER
Assistant Attorney General

515 Transportation Building
St. Paul, Minnesota 55155
(612) 296-2301

**ATTORNEYS FOR AMICUS CURIAE,
STATE OF MINNESOTA**

TABLE OF CONTENTS

	Page
STATEMENT OF INTEREST	2
SUMMARY OF ARGUMENT	4
ARGUMENT:	
DISALLOWANCE OF FEDERAL FUNDS FOR NURSING HOMES IGNORES THE INTENT OF CONGRESS IN FORMULATING THE MEDICAID PROGRAM AND WILL DISRUPT THE ORDERLY ADMINISTRATION OF THE MEDICAID PROGRAM	5
CONCLUSION	10

TABLE OF AUTHORITIES

	Page
<i>Pennhurst State School and Hospital v. Halder-</i> <i>man</i> , 451 U.S. 1 (1981)	5, 9
42 U.S.C. §1396a(a)(5)	2
42 U.S.C. §1396b(a)	2
42 U.S.C. §1396d(a)(15)	3
42 U.S.C. §1396d(a)(18)(B)	3
42 U.S.C. §1396d(c)	3, 6
42 U.S.C. §1396d(f)	2, 6

No. 83-2136

IN THE

Supreme Court of the United States

OCTOBER TERM, 1984

STATE OF CONNECTICUT,
DEPARTMENT OF INCOME MAINTENANCE,

Petitioner,

v.

MARGARET M. HECKLER, SECRETARY,
and THE UNITED STATES DEPARTMENT OF
HEALTH AND HUMAN SERVICES,

Respondents.

**BRIEF OF AMICI CURIAE THE STATES
OF ILLINOIS, CALIFORNIA, AND MINNESOTA
ON BEHALF OF THE PETITIONER**

The States of Illinois, California, and Minnesota as *amici curiae* respectfully join in the brief of the Petitioner State of Connecticut, Department of Income Maintenance, requesting that this Court reverse the decision of the United States Court of Appeals for the Second Circuit dated March 30, 1984.

STATEMENT OF INTEREST

The States of Illinois, California, and Minnesota have a direct financial and public policy interest in the outcome of this case. Illinois, California, and Minnesota have been involved in litigation concerning the same disallowance of federal Medicaid funds that underlies the Second Circuit decision before this Court for review.

The Illinois Department of Public Aid, the California Department of Health Services, and the Minnesota Department of Human Services are the "single state agencies" designated to administer the State plans for medical assistance under Title XIX of the Social Security Act, 42 U.S.C. §1396a(a)(5). The state agency draws up a medical assistance plan consistent with the guidelines contained in Title XIX and the regulations promulgated thereunder and submits it to the U.S. Department of Health and Human Services (HHS) for approval. Upon approval of the plan by HHS, the state becomes eligible for reimbursement for a portion of the expenditures made in providing specific types of medical assistance to eligible individuals under the plan. 42 U.S.C. §1396b(a).

There are two types of nursing homes qualified for federal funding for residents who are eligible for benefits under the Medicaid program—skilled nursing facilities (SNFs) and intermediate care facilities (ICFs). SNFs care for individuals who need daily nursing services in a residential setting but who do not require an in-patient hospital placement. *See* 42 U.S.C. §1396d(f). ICFs care for individuals who, because of their mental or physical condition, require institutional services above the level of room and board, but who do not require the level of care

provided by a hospital or skilled nursing facility. *See* 42 U.S.C. §1396d(c). The disallowance of federal funds at issue here concerns nine ICFs in Illinois, five SNFs in California, and three ICFs in Minnesota. Until the disallowance, these States' expenditures for services provided to residents of these homes had been eligible for federal financial participation under Section 1905(a) of the Social Security Act, 42 U.S.C. §1396d(a)(15). Each state claimed and received federal funding for such services throughout this period.

However, in 1979 and 1980, the Health Care Financing Administration (HCFA) of HHS retroactively disallowed the federal financial participation on the ground that all of these nursing homes should be considered "institutions for mental diseases" (IMDs) as that term is used in Title XIX of the Social Security Act, 42 U.S.C. §1396d(a)(18)(B).

The States of Connecticut, Illinois, California, and Minnesota each filed an application for review of the disallowance with the Departmental Grant Appeals Board of HHS. The Board subsequently considered these applications in a joint proceeding before the Departmental Grant Appeals Board, with each state raising similar issues respecting interpretation of the statutory term "institution for mental diseases." On December 4, 1981, the Board issued its Decision Number 231 upholding the disallowances against all four states.

This retroactive disallowance resulted in the loss of federal funding to the States in the amounts of \$4,261,162 to Illinois, \$2,329,401 to California, and \$896,159 to Minnesota for this audit period. While this represents a substantial loss of funding to the states, it is clear that if the Second Circuit's decision is affirmed the future loss will be many times greater, resulting in the deprivation of medical services to needy citizens of the states.

SUMMARY OF ARGUMENT

The IMD exclusion should not be applied to facilities such as the Illinois, California, and Minnesota nursing homes involved in this case. Congress has indicated consistently that the term "institution for mental diseases" applies to mental hospitals. It has never given any direction that the term should be extended to nursing homes, which it has encouraged as alternatives to mental hospital care. The States of Illinois, California, and Minnesota adopt in full the arguments set forth by the State of Connecticut in its brief. The extension of the "IMD" exclusion to cover ICFs and SNFs is contrary to the intent of Congress in carving out the exception and to the position consistently taken by HHS. Moreover, the expansion of the IMD exclusion to ICFs and SNFs violates the spirit and purpose of the cooperative federal-state Medicaid program.

ARGUMENT

DISALLOWANCE OF FEDERAL FUNDS FOR NURSING HOMES IGNORES THE INTENT OF CONGRESS IN FORMULATING THE MEDICAID PROGRAM AND WILL DISRUPT THE ORDERLY ADMINISTRATION OF THE MEDICAID PROGRAM

In *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1 (1981), this Court stated that when Congress acts under its spending power, as it does in the Medicaid program, its authority to compel states to act is more limited than under those portions of the Constitution which give express substantive powers to the federal government. Requirements imposed under the spending power are essentially contractual in nature, with the states agreeing to certain conditions in return for federal funds. In *Pennhurst*, this Court stressed the requirement that states have clear notice of such conditions, so that they may make an informed decision of whether to agree to the grant prerequisites. Congress' power did not include the right to surprise states with retroactive changes in the conditions attached to the grant. *Id.* at 17-18, 24-25. Where Congress did intend to impose specific conditions on the receipt of grants, "it has proved capable of saying so explicitly." *Id.* at 17. It is fundamental that if Congress cannot retroactively change the conditions attached to a grant, HHS, in administering the congressional enactment, cannot do so either.

Since the beginning of the Medicaid program, the law has distinguished between institutions for mental diseases and nursing homes (intermediate care facilities and skilled nursing facilities). An IMD, as the states understood it from legislative history and earlier administrative prac-

tice, is a traditional state operated mental hospital or its "functional equivalent."¹ Each of the states involved in this disallowance maintains state mental hospitals into which it places persons who need that type of care and for which no Medicaid funds are claimed. The nature of these placements is totally unambiguous, because their population consists of people whose mental illness is so severe that they need to be institutionalized in a mental hospital.

In contrast, nursing homes provide certain levels of nursing care expressly delineated in the statutes and regulations to people not so severely disabled as to require mental hospital care. *See, e.g.*, 42 U.S.C. §§1396d(c), (f). There has been absolutely no showing that the audited facilities provided anything more or less than the care specifically required to be provided in intermediate care and skilled nursing facilities under Medicaid law, nor has it been claimed that the patients were not in need of such services. Based on this, the states legitimately believed that Medicaid funds were properly claimable for the services to these patients.

The audit underlying this case specifically reversed the states' legitimate expectations. No longer was an IMD a state mental hospital or its "functional equivalent." Suddenly, any skilled nursing facility or intermediate care facility would be branded an IMD if, after months or even years of poring over medical records, federal auditors concluded that the facility had too many patients with

¹ A "functional equivalent" of a state mental hospital would be a private psychiatric facility serving people with the same severity of mental illness as those requiring public mental hospital care.

"mental" diagnoses,² was located too close to a state mental hospital, advertised that it provided care for persons with mental disabilities, received patients who had formerly been in state mental hospitals, or one of several other criteria totally unrelated to the type of care actually needed and received by the patients.

There is no suggestion in any of the legislative history of the IMD exclusion that an IMD would be so difficult to identify, requiring the expenditure of large amounts of time and resources. Congress seemed to think that a facility's status as an IMD would be quite obvious, as indeed it always has been to the states and to the public.

Congress also believed that IMDs were essentially undesirable places. This is quite clear from the legislative history as discussed by the petitioner State of Connecticut. Because of this, Congress required that persons who truly did not need an IMD be given a type of care more appropriate for them. This might be non-medical care not eligible for federal funding, or it might be medical care in a Medicaid-eligible facility which provides such care. Nowhere did Congress suggest that all of those persons who many years ago were commonly warehoused in IMDs would still somehow carry an "IMD" label when they are now appropriately placed into facilities to provide them with required nursing care, or that this label would taint

² One of the most pernicious aspects of the federal audits to seek out IMDs was the amazingly over-inclusive selection of patients for the label of "mental diagnosis". Auditors included persons suffering from senile dementia, alcoholism, brain trauma, brain damage due to drug overdose, psychotic behavior due to high fever, and similar conditions among those Medicaid recipients whose presence in a nursing home "proved" that the nursing home was an IMD.

those facilities to deprive them of Medicaid funding. Yet that is precisely the effect of the policy HHS seeks to vindicate in this action.

The states before this Court have struggled to provide better and more appropriate care for their mentally disabled residents than used to be the norm not so many years ago. In doing so, they have operated state mental hospitals (now much improved from their former "warehousing" function) for those patients who need such focused psychiatric care. No federal funds are claimed for these patients between the ages of 21 and 65.

For those patients who properly need routine skilled nursing care or intermediate care rather than confinement in a state hospital, the states have ensured access to private facilities providing such care. That is precisely what Congress required the states to do, and there is nothing in the legislative history which suggests that the states' compliance with Congress' will would remove the private facilities which provide this care from Medicaid eligible provider status.

It is important to recognize that this is *not* a case where HHS auditors found that the patients in these facilities did not need the care of skilled nursing or intermediate care facilities, or found that the services provided did not meet the requirements for such services found in Medicaid law.

What has happened here is quite different. These were not truly audits but rather the *ex post facto* gathering of data to justify a new policy. Learning that states had been placing into more appropriate environments those patients who would formerly have had nowhere to go but a state mental hospital, HHS somehow saw a state plot

to raid Medicaid funds. That attitude, which is quite clear from the documents produced before the HHS Departmental Grant Appeals Board, led to a redefinition of the term "institutions for mental diseases" and to the audits which began this case.

In cases such as *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1 (1981), this Court has recognized that states administering the many federal grant programs are in a uniquely vulnerable position. In order to claim and retain funds, they must administer complex programs with myriad detailed requirements, always at risk that the federal government, program beneficiaries, taxpayers, or some other interested party will claim that less or more money should have been spent. At the same time, states must budget their operating funds as best they can. This process is incredibly complex and difficult at best. If HHS can add to this the retroactive definition of what is and is not properly a Medicaid-eligible facility, the administrative difficulties become insurmountable. This Court has held in *Pennhurst* that states cannot lawfully be forced into this position by the federal government.

Amici states of Illinois, California, and Minnesota urge the Court to reaffirm that holding in this context and ensure that the legitimate expectations of the states which participate in the Medicaid program are not abused. To allow HHS to proceed as it has done with disallowances of federal funds claimed by states for ICFs and SNFs would totally disrupt the states' orderly administration of the Medicaid program and create a precedent for retroactive defunding of legitimate costs.

CONCLUSION

For the reasons stated in this brief and in the brief of the petitioners, *amici* respectfully urge this Court to reverse the decision of the court below.

Dated: January 2, 1985

Respectfully submitted,

NEIL F. HARTIGAN
Attorney General of Illinois

JILL WINE-BANKS
Solicitor General of Illinois

JAMES C. O'CONNELL *

BARBARA L. GREENSPAN
Special Assistant Attorneys General
130 North Franklin Street, Suite 300
Chicago, Illinois 60606
(312) 793-2380

ATTORNEYS FOR AMICUS CURIAE,
STATE OF ILLINOIS

JOHN K. VAN DE KAMP
Attorney General of California

THOMAS E. WARRINER
Assistant Attorney General

ELISABETH C. BRANDT
Deputy Attorney General
1515 K Street, Suite 511
Sacramento, California 95814
(916) 324-5365

ATTORNEYS FOR AMICUS CURIAE,
STATE OF CALIFORNIA

HUBERT H. HUMPHREY III
Attorney General of Minnesota

BEVERLY JONES HEYDINGER
Assistant Attorney General

515 Transportation Building
St. Paul, Minnesota 55155
(612) 296-2301

ATTORNEYS FOR AMICUS CURIAE,
STATE OF MINNESOTA

6
No. 83-2136

Office Supreme Court, U.S.
FILED

JAN 2 1985

ALEXANDER L. STEVAS,
CLERK

IN THE SUPREME COURT
OF THE UNITED STATES

OCTOBER TERM, 1984

STATE OF CONNECTICUT, DEPARTMENT
OF INCOME MAINTENANCE,

Petitioner,

v.

MARGARET M. HECKLER, Secretary
and the UNITED STATES
DEPARTMENT OF HEALTH AND
HUMAN SERVICES,

Respondents.

On Writ of
Certiorari To The United
States Court of Appeals
For the Second Circuit

BRIEF OF AMICUS CURIAE
Commonwealth of Massachusetts

FRANCIS X. BELLOTTI
ATTORNEY GENERAL
Commonwealth of Massachusetts

Thomas A. Barnico
Counsel of Record

William L. Pardee
Assistant Attorneys General
Dept. of the Attorney General
One Ashburton Place, Rm. 2019
Boston, MA 02108
(617) 727-1004

6728

TABLE OF CONTENTS

	<u>Page</u>
INTEREST OF AMICUS CURIAE	1
SUMMARY OF ARGUMENT	6
ARGUMENT	
I. THE SECRETARY'S DISALLOWANCE POWER DOES NOT INCLUDE THE POWER RETROACTIVELY TO ALTER CONDITIONS ON FEDERAL GRANTS.	11
A. Introduction	11
B. Conditions on Medicaid Reimbursement Must Be Clearly And Seasonably Stated.	15
C. Retrospective Disallowances on Substantive Grounds Contradict the Language and Spirit of Title XIX and Decisions of this Court.	19
D. Rectifying the Balance Between State and Federal Authority Under Title XIX Will Not Undermine the Secretary's Role.	29
II. THE SECOND CIRCUIT ERRED IN ADOPTING THE SECRETARY'S INTERPRETATION OF THE STATUTE.	32

Page

- A. The Interpretive Bases for the Secretary's Retrospective Disallowances Are Not Entitled To Judicial Deference. 32
- B. The Secretary's Attempts to Redefine Nursing Homes As Institutions For Mental Diseases Thwart Congressional Policies Toward Care of the Mentally Ill and Improperly Punish States that Have Implemented These Policies. 37
1. The Secretary's Position Defies Congressional Intent To Encourage the Development And Utilization of Alternatives To Mental Hospitals In Caring For the Mentally Ill. 38
2. The Secretary's Action Improperly Punishes States That Responded To Congressional Directives By Developing and Utilizing Alternatives to Mental Hospitals in Caring for the Mentally Ill. 52

CONCLUSION

TABLE OF AUTHORITIES

Page

CASES

American Shipbuilding Co. v. Labor Bd., 380 U.S. 300 (1965)	36
Batterton v. Francis, 432 U.S. 416 (1977)	35, 37
Bell v. New Jersey, 103 S. Ct. 2187 (1983)	15n, 29
Chevron v. Natural Resources Defense Council, 81 L. Ed. 2d 694 (1984)	35
Harris v. McRae, 448 U.S. 297 (1980)	17, 31
Hendrick Hudson Dist. Bd. of Ed. v. Rowley, 458 U.S. 176 (1982)	15
Labor Bd. v. Brown, 380 U.S. 278 (1965)	36
Medical Services Admin. v. U.S., 590 F. 2d 135 (5th Cir. 1979)	20n
Pennhurst State Hospital v. Halderman, 451 U.S. 1 (1978)	<u>passim</u>
Schweiker v. Gray Panthers, 453 U.S. 34 (1981)	34

	<u>Page</u>
Schweiker v. Wilson, 450 U.S. 221 (1981)	46
State of Conn. v. Heckler, 731 F. 2d 1053 (2d Cir. 1984)	12, 33n
State of Florida v. Mathews, 526 F. 2d 319 (5th Cir. 1976)	34
State of Minn. by Noot v. Heckler, 718 F. 2d 852 (8th Cir. 1983)	33n 37, 41n, 47n, 50
State of New Jersey v. Department of HHS, 670 F. 2d 1262 (3d Cir. 1981)	20n
U.S. v. Cartwright, 411 U.S. 546 (1973)	36
U.S. v. Vogel Fertilizer Co., 455 U.S. 16 (1982)	35, 36

CONSTITUTIONAL PROVISIONS

United States Constitution	13, 16
Article I, § 8, cl. 1	

STATUTES

42 U.S.C. § 242(b)	43
42 U.S.C. § 1302	34

	<u>Page</u>
42 U.S.C. § 1316(d)	21
42 U.S.C. § 1395x(k)	49
42 U.S.C. § 1396	45
42 U.S.C. § 1396a	25
42 U.S.C. § 1396a(a)(17)(B)	35
42 U.S.C. § 1396a(a)(20)	45, 47
42 U.S.C. § 1396a(a)(21)	47
42 U.S.C. § 1396a(a)(30)	49
42 U.S.C. § 1396a(a)(31)	49, 50
42 U.S.C. § 1396a(b)	30
42 U.S.C. § 1396b(a)	18, 22, 23, 24, 28, 30
42 U.S.C. § 1396b(d)(1)	26
42 U.S.C. § 1396b(d)(2)	27, 28
42 U.S.C. § 1396b(i)(4)	49
42 U.S.C. § 1396c	21, 26, 30
42 U.S.C. § 1396d(a)(1)	45
42 U.S.C. § 1396d(a)(4)(A)	40n
42 U.S.C. § 1396d(a)(14)	8, 11

	<u>Page</u>
42 U.S.C. § 1396d(a)(15)	40n, 47
42 U.S.C. § 1396d(a)(18)(B)	8, 11, 47
42 U.S.C. § 1396d(c)	39n
42 U.S.C. § 1396d(c)(1)	48
42 U.S.C. § 1396d(f)	39n
42 U.S.C. § 2689 (repealed, 1981)	44, 45
Mass. Gen. Laws. Ann. ch. 19	53
 <u>REGULATIONS</u>	
42 C.F.R. § 405.1121(1)1	50
42 C.F.R. § 435.1009(e)(2)	32
42 C.F.R. § 441.106	47n
42 C.F.R. § 442.306	50
42 C.F.R. § 456	50
 <u>LEGISLATIVE HISTORY</u>	
H.R. Rep. No. 694, 88th Cong., 1st Sess. 11, <u>reprinted in</u> [1963] U.S. Code Cong. and Ad. News 1054	46n

	<u>Page</u>
S. Rep. No. 404, 89th Cong., 1st Sess., <u>reprinted in</u> [1965] U.S. Code Cong. and Ad. News. 1943	46n, 47n
117 Cong. Rec. 44721 (1971)	48n
 <u>MISCELLANEOUS</u>	
2 R. Cappalli, Federal Grants and Cooperative Arrangements, §§ 8.13-8.16 (1982)	27
2 Davis, <u>Administrative Law Treatise</u> (2d ed. 1979)	35
J. Gudeman and M. Store, <u>Beyond Deinstitutionalization,</u> 311 New Eng. J. of Med. 832 (1984)	53n, 54n, 55n
National Institute of Mental Health, <u>Deinstitutionalization: An Analytical Review and Sociological Perspective,</u> 1, Series D, No. 4, Publication No. 76-351 (1976)	40n
Office of the [HHS] Inspector General, <u>Identification of Institutions for Mental Disease Under Title XIX,</u> Audit Report No. 01-20202 (1981)	41n

Page

Steering Committee on
the Chronically Mentally
Ill, Toward a National Plan
for the Chronically Mentally
Ill, 1-2, Report to the
Secretary (December 1980)

42n

United States Comptroller
General, Returning the Disabled
to the Community: Government
Needs to Do More, Report to the
Congress (1977)

43n

United States General Accounting
Office, Medicaid and Nursing Home
Care: Cost Increases and the
Need for Services Are Creating
Problems for the States
and the Elderly (Oct. 21, 1983)

56n

No. 83-2136

IN THE SUPREME COURT
OF THE UNITED STATES

OCTOBER TERM, 1984

STATE OF CONNECTICUT, DEPARTMENT
OF INCOME MAINTENANCE,

Petitioner,

v.

MARGARET M. HECKLER, Secretary
and the UNITED STATES
DEPARTMENT OF HEALTH AND
HUMAN SERVICES,

Respondents.

On Writ of
Certiorari To The United
States Court of Appeals
For the Second Circuit

INTEREST OF AMICUS CURIAE

The Commonwealth of Massachusetts
(the "Commonwealth") submits this brief
amicus curiae in support of the position
of the petitioner State of Connecticut.

The interests of the amicus relevant to the case are both legal and financial. The Commonwealth's legal interest encompasses the proper construction of the statutes which govern Medicaid reimbursement for services provided persons in institutions for mental diseases ("IMD"). The Commonwealth has recently appealed the Secretary's disallowance of \$1,142,092 in reimbursement for such services. (United States District Court for the District of Massachusetts. C.A. No. 83-2239-Mc). In that case, the Secretary has invoked substantially the same legal grounds for her disallowance as asserted in the Connecticut case. Accordingly, on the primary question of statutory construction posed by this case, the Commonwealth endorses the position of the petitioner State of

Connecticut.

On a more general level, as a party to the Medicaid contract with the Secretary, the Commonwealth has a profound interest in the related question: what are the parameters of the agreement between the United States and the States, and under what standards may the Secretary retrospectively disallow expenditures made in accordance with an approved state plan? This broad inquiry subsumes questions of whether, and to what degree, judicial deference is properly accorded the Secretary's retrospective interpretations of statutes and regulations under the Medicaid program.

The interests of the Commonwealth are financial as well. In addition to its District Court challenge to the IMD

disallowance, the Commonwealth also currently contests, in administrative and judicial forums, approximately eleven million dollars in disallowed reimbursement for services provided persons in intermediate care facilities for the mentally retarded. Several million are also at stake in a dispute concerning the reimbursement of "over-payments" to nursing homes. These costs, while significant, reflect only the previous targets of the Secretary; millions of dollars for other services may also fall under her aim. As a state which would bear the fiscal burdens imposed by (1) an adverse construction of the statute governing Medicaid reimbursement for services in institutions for mental diseases, and (2) an expansive

interpretation of the Secretary's power of retrospective disallowance, the Commonwealth of Massachusetts is well qualified to convey these concerns to the Court.

Finally, the Commonwealth asserts a policy interest in the consequences of the adoption of the Secretary's legal argument. Massachusetts currently provides treatment to many of its the mentally ill in its ICFs. The Commonwealth has a profound interest in maintaining Medicaid reimbursement for services in less intensive and expensive settings. To the extent that the Secretary's position would discourage treatment of the mentally ill in such settings, her argument would adversely affect important State programs.

SUMMARY OF ARGUMENT

I. This case poses an important and recurring issue at the heart of the Medicaid program: what is the nature and extent of the power of the Secretary to retrospectively disallow expenditures made by States in accordance with their approved state Medicaid plans?

As a general proposition, the Court has required Congress to seasonably and unambiguously express federal conditions on the States' receipt of grants under the Medicaid program. The Secretary's assertion of unilateral power retrospectively to interpret Title XIX and to disallow reimbursement on the basis of such post hoc interpretations offends this constitutional requirement.

Furthermore, Title XIX imposes only two conditions on federal reimbursement: first, the State must have an approved plan; and second, State expenditures must have been made under the plan. The power asserted by the Secretary to disallow federal reimbursement for expenditures on the basis of a retrospective interpretation of ambiguous statutory terms makes the federal bargain with the states illusory. Where the states incur expenditures in reliance upon the Secretary's approval of their plans, and where there is no countervailing congressional directive, the Secretary should be compelled to honor the federal promise of reimbursement.

II. On the central statutory question presented by this case, the

amicus endorses Connecticut's interpretation of the IMD exclusion. At the threshold, we demonstrate why the Secretary's construction of 42 U.S.C. §§ 1396d(a)(14) and (18)(B) should be given, at most, interpretive rather than legislative effect. Since Title XIX lacks any provision expressly delegating substantive rulemaking power to the Secretary to define IMDs, little, if any, judicial deference should be accorded the Secretary's statutory construction.

The proper construction of the IMD exclusion is best understood against the backdrop of the broader problem of the treatment of the mentally ill. The services provided the mentally ill by Massachusetts and other states in their

ICFs were not developed in a legislative vacuum. To the contrary, services outside traditional mental institutions were encouraged by Congress through Medicaid and other acts. Federal support for alternative services focused on the nature and degree of care required by the patient. The Secretary's definition of the term IMD ignores these efforts and focuses on the number of patients who are former or potential mental hospital patients. The restricted reimbursement which results frustrates the system promoted by Congress to ensure appropriate treatment of the mentally ill.

Finally, the Secretary's disallowance punishes states such as Massachusetts, that have committed substantial

efforts and resources to the development of alternatives to treatment in mental hospitals. State and national statistics demonstrate a significant trend toward deinstitutionalization, and a concomitant increase in the number of ICFs.

The available evidence thus shows that the States responded to congressional encouragement of alternative treatment. The Secretary's retrospective interpretation of the IMD exclusion effectively punishes the States for pursuing this course. The adoption of the Secretary's argument would seriously undermine future state efforts in the treatment of the mentally ill.

ARGUMENT

I. THE SECRETARY'S DISALLOWANCE POWER DOES NOT INCLUDE THE POWER RETROACTIVELY TO ALTER CONDITIONS ON FEDERAL GRANTS.

A. Introduction

The significance of this case transcends the financial consequences of the Secretary's expansive construction of the term "institution for mental diseases" found in 42 U.S.C. § 1396d(a)(14) and (18)(B). The case also poses another issue, one at the heart of the Medicaid program: in what circumstances are the States entitled to rely on the federal reimbursement promised by Congress in exchange for their participation in the Medicaid program? The Secretary has taken the position in many recent disallowance cases that the States are

entitled to partial reimbursement for their expenditures only if, in the Secretary's considerable discretion, she determines after the fact that those expenditures were lawful. This position is quite clearly asserted in the Brief for Respondents in Opposition to the Petition, at 8-9.

The Second Circuit in this case adopted this tilted view of the relationship between the Secretary and the States under the Medicaid program. The court concluded that "the IMD definition adopted by HHS and supplemented by its internal criteria reasonably implements Congress' intent." State of Connecticut v. Heckler, 731 F. 2d 1053, 1060 (2d Cir. 1984). In so ruling the court

treated the Medicaid program as an essentially regulatory program in which the views of the administering agency drive judicial interpretation of applicable statutes and regulations. However, Title XIX is an exercise of the spending power, not an assertion of federal regulatory control over the states. The relationship between the states and the federal government is essentially contractual in nature, and the terms of that relationship -- the conditions upon which the states receive federal grant money -- must be seasonably and unambiguously stated. Whatever the Secretary's regulatory powers may be under Title XIX, they do not include the power to alter -- or "interpret" -- the terms

of the federal agreement retrospectively in a disallowance proceeding. Such would amount to the power to "surpris[e] participating States with post-acceptance or 'retroactive' conditions," which is forbidden even to Congress. Pennhurst State School & Hospital v. Halderman, 451 U.S. 1, 25 (1978). Further, our analysis of the statutory terms of Title XIX will show that Congress did not attempt to confer any such power on the Secretary. Rather, Title XIX requires the Secretary to pay the federal share of all of the states' expenditures under an approved state plan, subject only to explicit statutory exceptions and the Secretary's lawful prospective interpretations.

B. Conditions on Medicaid Reimbursement Must Be Clearly And Seasonably Stated.

Since the decision of the Second Circuit will, if upheld, significantly increase the financial obligations of the Commonwealth and other states, the statutory language must be judged by the principle of statutory construction that "Congress must express clearly its intent to impose conditions on the grant of federal funds so that the States can knowingly decide whether or not to accept those funds." Pennhurst State School v. Halderman, 451 U.S. at 24. See Hendrick Hudson Dist. Bd. of Ed. v. Rowley, 458 U.S. 176, 204 n. 26 (1982).^{1/} Legislation such as the Medicaid statute,

^{1/} Unlike the situation in Bell v. New Jersey, 103 S. Ct. 2187 (1983), this

(footnote continued)

enacted pursuant to the spending power, is "in the nature of a contract: in return for federal funds, the States agree to comply with federally imposed conditions." Pennhurst, 451 U.S. at 17. Congress' power to legislate under the spending power rests on the States' "knowing acceptance" of the conditions of the "contract." Ibid. Conditions on the grant of federal monies must therefore be timely and "unambiguous." Ibid.

(footnote continued)

case turns on the question whether the disallowed sums were expended under the state plan. In the amicus' view, the Secretary's attempt in this and other cases to disallow federal financial participation on the basis of a post hoc (or undisclosed) interpretation of a vague statutory term (and equally vague regulation) amounts to the retroactive imposition of a new condition on the federal grant. See id. at 2197 n. 17; id. at 2199 (White, J., concurring).

The nature and purpose of the Medicaid program underscore the constitutional requirement of a clear and seasonable statement of contractual conditions. "The Medicaid program created by Title XIX is a cooperative endeavor in which the Federal Government provides financial assistance to participating states to aid them in furnishing health care to needy persons." Harris v. McRae, 448 U.S. 297, 308 (1980). The program is one of "cooperative federalism," in which the Federal Government agrees to pay a specified percentage of the total amount expended under the Medicaid plan submitted by the State and approved by the Secretary. Id. The purpose of Congress in enacting Title XIX was "to

provide Federal financial assistance for all legitimate state expenditures under an approved Medicaid plan." Id. (citation omitted). The Act expressly provides that the Federal Government will share the cost of a state's medical assistance program to the extent that the cost is incurred under a plan approved by the Secretary. 42 U.S.C. § 1396b(a).

For these reasons, the Court has indicated that such exercises of the spending power as that exemplified by the Medicaid program are governed by the rule that conditions imposed on the States must be seasonably and unambiguously expressed. Pennhurst v. Halderman, 451 U.S. at 22. We demonstrate below

that the Secretary's process of disallowance, which is based solely upon a retrospective interpretation of ambiguous statutory or regulatory terms, violates these limitations and contradicts the purpose and terms of Title XIX.

C. Retrospective Disallowances on Substantive Grounds Contradict the Language and Spirit of Title XIX and Decisions of this Court.

Since the "clear statement" rule recognized in Pennhurst governs the Medicaid program generally, id. at 22, the question becomes whether the process of audit, interpretation, and disallowance followed by the Secretary in this and similar cases comports with that rule and the purposes of Title XIX. If the Secretary's process is proper and her

power of disallowance clear, there remains the question whether the interpretive bases for the Secretary's retrospective disallowances are entitled to deference by reviewing courts.^{2/}

The authority to sanction a State for noncompliance, or to disallow claims, must be unambiguously noted in some provision of law applicable to the grant program under which the action is taken.

^{2/} We assume here that the Secretary's power of disallowance extends beyond mechanical or routine calculations, or the routine classification of claims for the purpose of determining the assistance percentage. That power is not free from doubt, however. See, e.g., State of New Jersey v. Department of HHS, 670 F. 2d 1262, 1274-75 (3d Cir. 1981); Medical Services Admin. v. United States, 590 F. 2d 135, 136 (5th Cir. 1979) (disallowance disputes usually turn on accuracy of audit).

Pennhurst, 451 U.S. at 17. The compliance procedure under 42 U.S.C. § 1396c specifically sets forth the grounds for federal action and limits relief to prospective withholding of payments. In contrast, the disallowance procedure is neither defined nor specifically authorized in the text of Title XIX. Section 1316(d) of 42 U.S.C. does not define the term, but provides as follows:

(d) Whenever the Secretary determines that any item or class of items on account of which Federal financial participation is claimed under Title I, VI, X, XIV, XVI, or XIX, or part A of subchapter IV of this chapter, shall be disallowed for such participation, the State shall be entitled to and upon request shall receive a reconsideration of the disallowance.

42 U.S.C. § 1316(d). Section 1316 appears in Title XI of the Social

Security Act, which contains general provisions applicable to many grant programs within the Act. The section itself was enacted with the caption "Administrative and Judicial Review of Certain Administrative Determinations." It does not explicitly empower the Secretary to disallow claims for federal financial participation for items of expense under any grant program. In the absence of such enabling language, authority for the disallowance procedure must be found in the provisions of Title XIX.

The starting (and ending) point in the search for conditions imposed on grants under Title XIX, and, hence, in the search for disallowance authority, is 42 U.S.C. § 1396b. Subsection (a) of

that section provides that

the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this subchapter . . .

(1) an amount equal to the Federal medical assistance percentage . . . of the total amount expended during such quarter as medical assistance under the State plan

The remaining subsections, except subsection (d), set forth exceptions to this general rule. In short, Title XIX imposes exactly two general conditions upon federal financial participation in a State's medical assistance expenditures. First, the State must have an approved plan; second, the State's expenditures must have been made under the State plan. Notably absent is any provision permitting disallowance of items of expendi-

ture under the State plan; if the expenditure is made under an approved plan, § 1396b(a) requires that it be reimbursed.^{3/} The absence of additional conditions is not an oversight; rather, it reflects the contractual nature of the state and federal governments' mutual undertakings. Section 1396b(a) implicitly recognizes that if a state undertakes to operate a program or plan which, it is assured, meets federal criteria, it is entitled to rely on the federal government to bear that part of the burden which it has said it will bear. Congress did not reserve to the Secretary

^{3/} We do not dispute the Secretary's power in general to disallow claims for assistance to ineligible recipients or uncertified providers. These would not be expenditures under the plan.

the right to reconsider her approval of a plan, in order to deny federal participation in expenditures already incurred by the State. Such a reservation would verge on a claim of right to "surpris[e] participating States with post-acceptance or 'retroactive' conditions." Pennhurst State School v. Halderman, 451 U.S. at 25.

It follows that a doubt on the Secretary's part as to whether an approved plan complies with § 1396a cannot form the basis of a disallowance. When the Secretary has second thoughts about the acceptability of a State plan, the course provided by law is to notify the State of her doubts, hold a hearing, and, if her doubts survive the hearing and

judicial review, to prospectively withhold payment. 42 U.S.C. § 1395c.^{4/}

In a number of recent disallowance cases, the Secretary has identified § 1396b(d) as the wellspring of her power to disallow expenditures made in accordance with the state plan on the basis of after-the-fact interpretations of Title XIX or of her regulations. Under § 1396b(d)(1), the Secretary is required to "estimate the amount to which a state will be entitled under subsections (a)

^{4/} Thus, insofar as the Secretary is vested with regulatory authority, she may use that authority to alter or supplement program requirements prospectively. In this part, the amicus simply contests the Secretary's power to give her regulatory actions retrospective effect.

and (b) of this section" prior to the start of each quarter. Under § 1396b(d)(2), the Secretary is required to pay to the States "the amount so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter" The Secretary does not merely claim that she may offset past overpayments against current payments under this section. Such would be a usual feature of a grant program. See, e.g., 2 R. Cappalli, Federal Grants and Cooperative Arrangements §§ 8.13-8.16 (1982). Rather, the Secretary claims that this language gives her power to

make a unilateral determination, to which reviewing courts must defer, and which is therefore binding on the states, that a particular expenditure is not reimbursable. However, while such a power may be a feature of regulatory programs, it is unusual to say the least in a contractual setting. Moreover, it is not consonant with the requirement of § 1396b(a) that the Secretary pay the federal share of state expenditures under an approved plan. Since it is not a required reading of § 1396b(d)(2); since it would be an unusual and harsh power in a contractual setting; and since it does not harmonize with the tenor of Title XIX as a whole, the Secretary's reading of this provision should be

rejected under the "clear statement" rule of Pennhurst, supra. See also Bell v. New Jersey, 103 S. Ct. 2187, 2199 (1983) (White, J. concurring).

D. Rectifying the Balance Between State and Federal Authority Under Title XIX Will Not Undermine the Secretary's Role.

The argument against the Secretary's asserted power to disallow federal participation on the basis of a post hoc interpretation of statutory conditions does not threaten Federal supervision of the Medicaid program. The Secretary's interest in the program is adequately protected without the power of substantive, retrospective disallowance.

At a general level, the Secretary retains authority to specify the

contents of state plans and approve or disapprove these plans. 42 U.S.C. §§ 1396, 1396a(b). The Secretary can enforce compliance with the plan through appropriate proceedings. 42 U.S.C. § 1396c. These exercises of authority place the states in the same or a greater position of risk than the Secretary.^{5/}

The Secretary also benefits from the particular protection which resides with the congressional power of amendment. Section 1396b(a) provides that "the Secretary (except as otherwise provided

^{5/} Of course the states, as financial partners in Medicaid, bear an equal financial risk, which in itself is a powerful stimulus to accurate administration.

in this section) shall pay" Congress may thus condition the prospective obligations of the Federal Government, provided that it does so seasonably and unambiguously. Congress has not, however, reserved to the Secretary the right to retrospectively disapprove state expenditures which were made properly, in accordance with the state plan; it has not empowered the Secretary to renege on the federal promise. See Harris v. McRae, 448 U.S. at 309 (1980). The nullification of the Secretary's asserted power of retrospective interpretation and disallowance, therefore, would do no more than restore to the federal-state relationship the balance intended by Congress.

II. THE SECOND CIRCUIT ERRED IN ADOPTING
THE SECRETARY'S INTERPRETATION OF
THE STATUTE.

A. The Interpretive Bases for the
Secretary's Retrospective Dis-
allowances Are Not Entitled To
Judicial Deference.

In the preceding section, the amicus argued that the Secretary may not base a disallowance on a post hoc interpretation of an ambiguous statute or regulation. Such, it is submitted, is the Secretary's regulation defining the term "institution for mental diseases" as one "engaged in providing diagnosis, treatment or care of persons with mental diseases"^{6/} 42 C.F.R. § 435.1009(e)(2).

^{6/} On its face, the regulation could refer to traditional mental hospitals, or to institutions primarily engaged in treating the mentally ill as such. See

(footnote continued)

If the Court nevertheless determines either that the post hoc interpretation of the regulation suffices or that the regulation is unambiguous, the question remains whether the Secretary's reading is consistent with federal law. This question subsumes two others: first, what if any deference should be given to the Secretary's regulation; second, is the regulation consistent with the statute it purports to interpret? The amicus turns to these questions.

The Social Security Act authorizes the Secretary to publish rules and

(footnote continued)

Minnesota v. Heckler, 718 F. 2d 852, 862 (8th Cir. 1983). The Secretary's view draws its strength, not from the regulation, but from the intra-office memorandum specifying criteria to be used in assessing an institution. See Connecticut v. Heckler, 731 F. 2d at 1054.

regulations "not inconsistent with [the] Act, as may be necessary to the functions with which [she] is charged under [the] Act." 42 U.S.C. § 1302. E.g., State of Florida v. Mathews, 526 F.2d 319, 323 n. 9 (5th Cir. 1976). This general authority must be contrasted with the Secretary's exceptionally broad "authority to prescribe standards for applying certain sections of the [Social Security] Act," discussed in Schweiker v. Gray Panthers, 453 U.S. 34, 43 (1981) (emphasis supplied). There, the Court upheld the Secretary's regulations defining eligibility requirements under the Social Security Act because the Act explicitly delegated to her the substantive authority to determine eligibility standards. See

42 U.S.C. § 1396a(a)(17)(B).^{7/}

In the absence of an express delegation of substantive rulemaking authority, the Secretary's promulgation of regulations under the Medicaid program should be given interpretive rather than legislative effect. See, e.g., Chevron v. National Resources Defense Council, 81 L. Ed. 2d 694, 703 (1984); Batterton v. Francis, 432 U.S. 416, 424-6 (1977); United States v. Vogel Fertilizer Co., 455 U.S. 16, 24-25 (1982). See generally 2 Davis, Administrative Law Treatise at 36-63 (2d ed. 1979). Furthermore, while

^{7/} 42 U.S.C. § 1396a(a)(17)(B) provides that states must grant benefits to eligible persons, "taking into account only such income and resources as are available as determined in accordance with standards prescribed by the Secretary, to the applicant."

some deference is ordinarily owing to an agency's interpretation of its own regulation, this general principle "only sets 'the framework for judicial analysis; it does not displace it.'" Vogel, 455 U.S. at 24, quoting from United States v. Cartwright, 411 U.S. 546, 550 (1973). "The deference owed to an expert tribunal cannot be allowed to slip into a judicial inertia which results in the unauthorized assumption by an agency of major policy decisions properly made by Congress." Labor Board v. Brown, 380 U.S. 278, 292 (1965), quoting from American Shipbuilding Co. v. Labor Board, 380 U.S. 300, 318 (1965).

Finally, where an agency's interpretation does not reflect an exercise of expressly delegated congressional

authority to prescribe substantive standards for determining the meaning of the statutory phrase, the question must be resolved by the court. See Batterton v. Francis, supra; State of Minn. by Noot v. Heckler, 718 F. 2d 852, 860, 865 (8th Cir. 1983).

As the amicus will next show, the Secretary's interpretation of the statutory terms governing reimbursement of services at IMD's undermines a key component of the States' Medicaid programs.

B. The Secretary's Attempts To Redefine Nursing Homes As Institutions For Mental Diseases Thwart Congressional Policies Toward Care of The Mentally Ill and Improperly Punish States That Have Implemented These Policies.

The amicus joins Connecticut in its exposition of the statute at issue here. In this part, the amicus will state its

own understanding of the congressional purpose, in light of the broad problem of the institutionalized mentally ill. The amicus believes that neither legislative meaning nor the implications of the Secretary's position can be adequately understood except in this broader context.

1. The Secretary's Position Defies Congressional Intent To Encourage the Development And Utilization of Alternatives To Mental Hospitals In Caring For The Mentally Ill.

The current attempts by the Secretary to redefine skilled nursing facilities (SNFs) and intermediate care facilities (ICFs)^{8/} as institutions for mental

^{8/} Skilled nursing facilities and intermediate care facilities are two types of nursing homes that differ according to the intensity of care provided.

(footnote continued)

diseases (IMDs) were prompted, in part, by the deinstitutionalization of the mentally ill that has occurred during the past twenty-five years. This movement, prompted in part by federal financial incentives, resulted in the release of thousands of mental hospital patients into the community. It also led to the development and utilization of alternative facilities, such as ICFs and SNFs, and other community-based services, to provide more appropriate care for these

(footnote continued)

Compare 42 U.S.C. § 1396d(f) with 42 U.S.C. § 1396d(c). Although the case before the Court involves only ICFs, HHS intends to use the same criteria in determining whether SNFs are IMDs. Therefore, many of the arguments advanced in this brief regarding ICFs would apply equally to SNFs. For this reason, we use the phrase "nursing home" to refer jointly to ICFs and SNFs.

individuals.^{9/} As a result, many ICFs and SNFs now care for large numbers of patients who are former mental hospital patients or, who, in the absence of alternative care, might have been initially placed in a mental hospital.

In response to the influx of these individuals into nursing homes, the Secretary has decided to ignore statutory language providing Medicaid coverage for SNF and ICF services,^{10/} and to redefine certain nursing homes that provide

9/ See, e.g., National Institute of Mental Health, "Deinstitutionalization: An Analytical Review and Sociological Perspective," 1, Series D, No. 4, Publication No. 76-351 (1976).

10/ See 42 U.S.C. §§ 1396d(a)(4)(A), (a)(15).

services to many of these patients as IMDs.^{11/} As demonstrated below, this response to the deinstitutionalization of the mentally ill directly conflicts with the congressional policy of

11/ HHS has freely admitted that the basis for its attempts to redefine certain ICFs and SNFs as IMDs is the influx of former mental patients into these nursing homes. See Office of the [HHS] Inspector General, Identification of Institutions for Mental Disease under Title XIX of the Social Security Act, Massachusetts Department of Public Welfare I, Audit Report No. 01-20202 (1981) [hereinafter cited as Audit Report].

In response to this influx, HHS developed the criteria upon which the disallowance in this case is based. HHS Field Staff Information and Instruction Series (FSIIS) FY-76-156 (Sept. 14, 1976); FY-76-97 (May 3, 1976); FY-76-44 (Nov. 7, 1975). See Minnesota v. Heckler, 718 F.2d 852, 862 (8th Cir. 1983).

encouraging appropriate care and treatment of the mentally ill and the development of alternatives to mental hospitals.

The deinstitutionalization movement resulted in part from the growing national awareness in the 1950's of the conditions in state mental hospitals.^{12/} Concerns about the plight of the patients in these institutions led Congress to establish new national legislation and policy toward the treat-

^{12/} E.g., Steering Committee on the Chronically Mentally Ill, Toward a National Plan for the Chronically Mentally Ill I-2, Report to the Secretary (December, 1980).

ment of the mentally ill.^{13/} Initially, in 1955, Congress passed the Mental Health Study Act. Act of July 28, 1955, c. 417, § 3, 69 Stat. 382, codified at 42 U.S.C. § 242b. This Act established the Joint Commission on Mental Illness and Health, and authorized it to conduct a nationwide study of the human and economic problems of mental illness and to recommend solutions to Congress. In a report that was to become the cornerstone for the deinstitutionalization movement, the Commission recommended: establishment of community-based programs for the

^{13/} See Comptroller General of the United States, Returning the Disabled to the Community: Government Needs to Do More, Report to the Congress, Appendix I (list of relevant federal legislation) (1977) [hereinafter cited as Comptroller General's Report].

mentally ill; reduction in the number of institutionalized mentally ill patients; improvements in the care of those who remained in institutions; creation of community-based after-care, intermediate care and rehabilitation services; and expansion of the federal role in sharing with state and local governments the costs of providing mental health care.^{14/}

Following this report, Congress enacted in 1963 the Mental Retardation Facilities and Community Mental Health Centers Construction Act, 42 U.S.C.

^{14/} Joint Commission on Mental Illness and Health, Action for Mental Illness, Report to the Congress (1961), cited in Comptroller General's Report, supra note 13 at 205.

§ 2689 (repealed in 1981), which encouraged the development of community-based services for the mentally ill by authorizing federal funds for the construction of community mental health centers. Two years later, in 1965, Congress provided further federal financial support for the care of the mentally ill when, in enacting the Medicaid program, 42 U.S.C. §§ 1396 et seq., it provided Medicaid reimbursement for inpatient care for the mentally ill in general medical facilities, 42 U.S.C. § 1396d(a)(1), and for IMD services for individuals who are over the age of sixty-five. 42 U.S.C. §§ 1396a(a)(20), (21).^{15/} Congress al-

^{15/} Congress chose not to include Medicaid reimbursement for IMD services for patients under age sixty-five because it
(footnote continued)

lowed this coverage, however, only on the condition that states continue to develop alternatives to mental hospitals (IMDs) in caring for the mentally ill of

(footnote continued)

wished to discourage the use of state mental hospitals in treating the mentally ill. See S. Rep. No. 404, 89th Cong., 1st Sess., reprinted in [1965] U.S. Code Cong. and Ad. News 1943, 2084-85. "The residual exclusion of large state institutions for the mentally ill from federal assistance rests on two related principles: states traditionally have assumed the burdens of administering this form of care, and the Federal Government has long distrusted the economic and therapeutic efficiency of large mental institutions." Schweiker v. Wilson, 450 U.S. 221, 242 (1981) (Powell J., dissenting), citing S. Rep. No. 404, supra, reprinted in [1965] U.S. Code Cong. and Ad. News at 2084. See H.R. Rep. No. 694, 88th Cong., 1st Sess. 11, reprinted in [1963] U.S. Code Cong. and Ad. News 1054, 1064. Congress determined, however, that the availability of appropriate alternatives to mental hospitals was particularly a problem for the elderly and, thus, allowed an exception for them.

all ages. 42 U.S.C. § 1396a(a)(20), (21).^{16/}

Congress further extended Medicaid coverage for care of the mentally ill in 1971. Amendments to Title XIX provided for reimbursement of "intermediate care facility services," see 42 U.S.C. § 1396d(a)(15), for "individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is assigned to provide, but who because of their mental or physical condition require care and services . . . which can be made available to them only through institutional

^{16/} Minnesota v. Heckler, 718 F. 2d at 864, citing S. Rep. No. 404, reprinted in [1965] U.S. Code Cong. and Ad. News at 2085. See 42 U.S.C. §§ 1396a(a)(20), (21); 42 C.F.R. § 441.106.

facilities." 42 U.S.C. § 1396d(c)(1) (emphasis added). Congress specifically added this coverage to ensure the availability of intermediate care for those who needed it, and who "in the absence of . . . [such care] would require placement in a skilled nursing home or mental hospital."^{17/} In providing this coverage, Congress recognized that there were individuals who had mental disabilities but who, nevertheless, did not require placement in traditional psychiatric facilities. Thus, Congress defined an ICF not by the Secretary's standard of whether large numbers of the

^{17/} Report of the Senate Finance Committee, printed in Statement of Senator Long, 117 Cong. Rec. 44721 (1971).

facility's patients might otherwise have been mental hospital patients, but by the actual nature and degree of care needed by these patients.

Congress also provided a system to ensure that a patient's needs are fully and appropriately met at a particular facility. 42 U.S.C. §§ 1396b(i)(4); 1396a(a)(30), (31); 1395x(k). This system of "independent professional review" or "utilization control review" provides for independent reviews by health-care professionals of a patient's needs and of the appropriateness of placement, both prior to admission in a facility and periodically thereafter. The review examines the feasibility of meeting the patient's needs through alternative services. 42 U.S.C. § 1396a(a)(31); 42

C.F.R. § 456.^{18/} Congress also established a system of professional review to ensure that when a patient needs services, such as intensive psychiatric services, which a nursing home is not equipped to provide, the patient either is transferred from the nursing home or is not accepted by that facility.^{19/}

By providing Medicaid coverage for ICF services, Congress intended to encourage the development and use of ICFs as alternatives to state mental

^{18/} See Senate Finance Committee Report, supra note 17 (emphasis on the role of the independent professional review team in assuring appropriate placement); Minnesota v. Heckler, 718 F. 2d at 866 n. 27.

^{19/} See 42 C.F.R. §§ 405.1121(1)(1), 442.306.

hospitals for individuals who might otherwise require psychiatric hospitalization. Congress further ensured the appropriate use of nursing homes through the system of utilization review.

Contrary to the will of Congress, the Secretary now seeks to redefine ICFs as IMDs based on factors relating not to the patients' actual needs, but to the number of a facility's patients who are former or potential mental hospital patients. In so doing, the Secretary contradicts specific congressional intent regarding Medicaid coverage of nursing home services, and general congressional policy toward treatment of the mentally ill. The Secretary also exceeds her authority by ignoring the statutory focus

on the services required by and provided to a patient, and by frustrating the system established by Congress for ensuring appropriate placement and treatment of the mentally ill.

2. The Secretary's Action Improperly Punishes States That Responded To Congressional Directives By Developing And Utilizing Alternatives To Mental Hospitals In Caring for The Mentally Ill.

Relying upon Congressional financial incentives and directives regarding the care of the mentally ill, many states have developed alternative facilities and services to replace mental hospitals.^{20/} Nearly twenty years ago, while Congress first wrestled with the problems of the mentally ill, the

^{20/} Between 1955 and 1980, the resident populations of public mental hospitals

(footnote continued)

Massachusetts General Court enacted the Comprehensive Mental Health and Retardation Services Act of 1966, St. 1966, Ex. Sess., ch. 735, Mass. Gen. Laws Ann. ch. 19, §§ 1 et seq., which established a comprehensive statewide program to deliver mental health services at the community level. Massachusetts subsequently developed a wide variety of community-based services for the mentally ill which now include, in addition to nursing homes and inpatient psychiatric hospitals, outpatient day treatment, twenty-four hour emergency, diagnostic and consultation services, vocational and educational

(footnote continued)

decreased nationally by about 75%, from 559,000 to 138,000. J. Gudeman and M. Shore, Beyond Deinstitutionalization, 311 New Eng. J. of Med., 832 (1984).

workshops, and various other facilities. These programs, excluding nursing home services, serve over 100,000 individuals each year, of which approximately 92% are treated through community-based residential, outpatient, or support services. Only 8% of the individuals were treated through state mental hospitals and inpatient mental health center services.^{21/}

This network of community-based alternatives to institutionalization differs markedly from the stark absence of publicly funded alternative care available prior to 1966. At that time, there existed one community mental health

^{21/} In fact, by 1981, 90% of former state hospital patients were in alternative settings. J. Gudeman and M. Shore, supra note 20 at 883.

center and a scattering of child guidance clinics. Eleven state mental hospitals housed over 20,000 patients. In fact, current estimates are that state mental hospital populations have decreased from roughly 23,000 in 1960 to the current level of about 2000.^{22/}

Like other states, Massachusetts responded to federal financial incentives, offered primarily through the Medicaid program, to further the development and utilization of nursing homes. The Federal Government has estimated that, nationally, nursing home populations grew an average of 8.1% annually between 1963, the year of the Mental Retardation Facilities and Community Mental Health

^{22/} J. Gudeman and M. Shore, supra note 20 at 833.

Centers Construction Act,^{23/} and 1973, with the greatest growth occurring after Medicaid was enacted in 1965.^{24/} This trend continues today in Massachusetts, which shows an 18% increase in the number of nursing home beds available between 1971 and the present.^{25/} Thus, Massachusetts statistics show that, as

23/ General Accounting Office, Medicaid and Nursing Home Care: Cost Increases and the Need for Services Are Creating Problems for the States and the Elderly (Report to the Chairman of the Subcommittee on Health and the Environment, Committee on Energy and Commerce, House of Representatives) (Oct. 21, 1983).

24/ See, e.g., Comptroller General's Report, supra note 13, at 8.

25/ The number of nursing home beds available in Massachusetts increased from 39,512 in December, 1971, to 46,521 in December, 1984.

the state mental hospital populations declined, the Commonwealth developed other forms of care, such as community mental health services and nursing homes.

The Massachusetts experience exemplifies the nationwide response to congressional encouragement of the development and utilization of nursing homes and other alternatives to mental hospitals. The Secretary now attempts, however, to disallow retroactively the federal share of Medicaid paid to many of these nursing homes. These efforts by the Secretary not only are misguided and contrary to congressional intent; they also unfairly punish states such as Massachusetts which, in a spirit of "co-operative federalism," responded to Congressional directives and Medicaid

program requirements for care of the mentally ill.

CONCLUSION

For the reasons set forth above, the judgment of the Court of Appeals for the Second Circuit should be reversed.

FRANCIS X. BELLOTTI
ATTORNEY GENERAL
Commonwealth of Massachusetts

Thomas A. Barnico
Assistant Attorney General
Department of the Attorney General
One Ashburton Place
Boston, MA 02108
(617) 727-1004
Counsel of Record

William L. Pardee
Assistant Attorney General

On the brief:

Leah W. Sprague
General Counsel

Lori G. Pearlman
Assistant General Counsel
Massachusetts Department of
Public Welfare

18
No 83-2136

IN THE
Supreme Court of the United States

OCTOBER TERM, 1984

STATE OF CONNECTICUT
DEPARTMENT OF INCOME MAINTENANCE,
Petitioner,

v.

MARGARET M. HECKLER, SECRETARY, AND THE UNITED
STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Respondents.

On Writ Of Certiorari To
The United States Court of Appeals
For The Second Circuit

JOINT APPENDIX

REX E. LEE
Solicitor General
KENNETH S. GELLER
Deputy Solicitor General
KATHRYN A. OBERLY*
Assistant to the
Solicitor General
Department of Justice
Washington, D.C. 20530
(202) 633-2217
Attorneys for Respondents

CHARLES A MILLER*
MICHAEL A. ROTH
ROBIN J. ARMBRUSTER
COVINGTON & BURLING
1201 Pennsylvania Avenue,
N.W.
P.O. Box 7566
Washington, D.C. 20044
(202) 662-6000
Attorneys for Petitioner

PETITION FOR CERTIORARI FILED
JUNE 28, 1984
CERTIORARI GRANTED OCTOBER 29, 1984
**Counsel of Record*

TABLE OF CONTENTS

	Page
APPENDIX A—Review of Costs Claimed by the Connecticut Department of Income Maintenance For Services Provided to Title XIX Recipients Residing at Middletown Haven Rest Home, Middletown, Connecticut, for the period January 1, 1977 through September 30, 1979 (FM Control No. 3-8001) (1980)	1a
APPENDIX B—Transcript Excerpts from the Testimony of Margaret Lempitsky	1b
APPENDIX C—Transcript Excerpts from the Testimony of Lawrence W. Osborne	1c
APPENDIX D—Field Staff Information and Instruction Series: FY-76-44, FY-76-97, and FY-76-156	1d
APPENDIX E—Letter from Mildred L. Tyssowski, Director, Bureau of Program Operations, Health Care Financing Administration to Edward W. Maher, Commissioner, Connecticut Department of Income Maintenance	1e

1a

**APPENDIX A
HEALTH
CARE
FINANCING
ADMINISTRATION**

**BOSTON REGION:
CONNECTICUT, MAINE, MASSACHUSETTS,
NEW HAMPSHIRE, RHODE ISLAND, VERMONT**

FM CONTROL NO. 3-8001

**Review of Costs Claimed by the Connecticut
Department of Income Maintenance for Services
Provided to Title XIX Recipients Residing at
Middletown Haven Rest Home
Middletown, Connecticut**

**For the Period
January 1, 1977 Through September 30, 1979
May 1980**

**DEPARTMENT OF HEALTH, EDUCATION, AND
WELFARE
REGION I**

**JOHN F. KENNEDY FEDERAL BUILDING
GOVERNMENT CENTER
BOSTON, MASSACHUSETTS 02203**

MAY 8, 1980

**In reply refer to:
HCFA/MB/DM**

**HEALTH CARE
FINANCING
ADMINISTRATION
Medicaid**

Audit Control No. 38001

EDWARD W. MAHER, Commissioner
Department of Income Maintenance
110 Bartholomew Avenue
Hartford, Connecticut 06106

Dear Commissioner Maher:

Enclosed are two copies of our final report covering a "Review of Costs Claimed by the Department of Income Maintenance for Services Provided to Title XIX Recipients Residing at Middletown Haven Rest Home in Middletown, Connecticut." Your comments of April 18, 1980 on the draft report are also incorporated in this report.

With respect to the fiscal disallowance of \$1,634,655 FFP for payments to Middletown during the period January 1, 1977 through September 30, 1979, a formal disallowance letter will be forthcoming through our Central Office. Similar disallowances for subsequent periods will also be processed, until we have been provided sufficient assurance that the situations identified in this report no longer exist. We would also appreciate being informed of all proposed corrective action, to minimize loss of any additional Federal funds.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), this report is available, upon request, to members of the press and general public to the extent that the information contained therein is not subject to exemptions in the Act, which the Department chooses to exercise. (See Section 5.71 of the Department's Public Information Regulation, dated August 1974, as revised).

If you have any further questions on this matter, do not hesitate to call me.

Sincerely yours,

ALFRED G. FUOROLI
Regional Medicaid Director
Medicaid Bureau

FM CONTROL NO. 3-8001

**Review of Costs Claimed by the Connecticut
Department of Income Maintenance for Services
Provided to Title XIX Recipients Residing at
Middletown Haven Rest Home
Middletown, Connecticut**

For the Period

January 1, 1977 Through September 30, 1979

**HEALTH CARE FINANCING ADMINISTRATION
MEDICAID BUREAU
REGION I
BOSTON, MASSACHUSETTS
MAY 1980**

REVIEW TEAM MEMBERS

WILLIAM DOYLE, AUDITOR, TEAM LEADER

PAUL DUVAL, PROGRAM SPECIALIST — CONNECTICUT MEDICAID
STATE REPRESENTATIVE

DR. LAWRENCE OSBORN, PSYCHIATRIST CONSULTANT ON LOAN
FROM UNITED STATES PUBLIC HEALTH SERVICE

NANCY MCGILLVARY, PSYCHIATRIC NURSE, MASS. DMH
RETAINED ON A CONSULTING BASIS

WALTER WILLOUGHBY, FINANCIAL MANAGEMENT SPECIALIST

DEBORAH CALLAHAN, FINANCIAL ASSISTANT

CAROL BERMAN, STUDENT TRAINEE

TABLE OF CONTENTS

	Page No.
INTRODUCTION	
Background	1
Scope of Review	3
RESULTS OF REVIEW	4
Federal Regulations	5
Medicaid Bureau Guidelines	5
Review of Facility to Determine Compliance with Bureau Guidelines	6
1. Licensed as a mental institution	6
2. Advertises or holds itself out as a mental institution	7
3. More than 50% of the patients have a disability in mental functioning	7
4. Used by mental hospitals for alternative care ..	8
5. Admitted mental patients from the community that may otherwise have entered a mental hospital	9
6. Proximity to a state mental institution	10
7. Age distribution is uncharacteristic of nursing home patients	10
8. Basis of Medicaid eligibility for patients under 65 is due to a mental disability, exclusive of services in an institution for mental disease	11
9. Hires staff specialized in the care of the men- tally ill	12
10. Independent professional reviews conducted by state teams report a preponderance of mental illness patients in facility	12

Table of Contents (Continued)

	Page No.
SUMMARY	14
Recommendations and State Agency Comments ...	14
ATTACHMENTS	
Attachment A: Discharge and Placement Policies of the Department of Mental Health	15
Attachment B: Regional Office Comments Regard- ing Discharge and Placement Policies of the De- partment of Mental Health	18
Attachment C: State Plan Provisions	21
Attachment D: State License Agreements	23
Attachment E: Admission Policies of Facility	29
Attachment F: Comments from Psychiatrist Consultant	32
APPENDIX — STATE AGENCY COMMENTS TO DRAFT REPORT	36

INTRODUCTION

Background

Title 42 CFR 435.1009 defines an institution for mental disease (IMD) as "an institution that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such." The Connecticut Department of Income Maintenance has elected through its approved State plan to exclude services to the mentally ill in IMD's as a covered service under the Medicaid program. Accordingly, payments provided for such services are not eligible for Federal Financial Participation.

There have been recent indications that the State of Connecticut has been discharging large numbers of mentally ill patients from State mental institutions into skilled nursing facilities (SNF's) and intermediate care facilities (ICF's). The first official evidence became available when reviews conducted by the Health Care Financing Administration's (HCFA) Regional Office of Health Standards and Quality Bureau identified an unusual patient mix in Lorraine Manor of Hartford, Connecticut. The Bureau's report stated that about 100 of the 220 or 45 percent of the patients residing in this skilled nursing facility were diagnosed as having a psychiatric illness at the time of their review in May 1979. These patients were almost all admitted from Fairfield Hills Hospital, a State-operated psychiatric hospital. On the basis of this report, the Regional Medicaid Director issued a letter to the Connecticut State agency on June 11, 1979, deferring reimbursement of Federal Financial Participation for payments made to Lorraine Manor on behalf of Title XIX recipients for the

quarter ended March 31, 1979. The grounds for this decision was the lack of assurance that the facility was not an institution for mental disease or possibly an institution for mental retardation.

Following the above action, meetings were held with State agency officials to discuss the issue raised at Lorraine Manor. State agency officials were told that there was evidence that the situation at Lorraine Manor was only one instance of a much larger state-wide problem which needed to be addressed. The Regional Medicaid Director asked that the State undertake an in-depth review of patient discharges from State mental institutions. On July 18, 1979, State officials from the Department of Income Maintenance, the Department of Mental Health (DMH), and the Governor's office, agreed to the following commitments:

1. That all further discharges from public institutions for the mentally ill into SNF's and ICF's would be discontinued until an acceptable discharge policy was put in place.
2. That all mentally ill patients in general care facilities would be reviewed by staff from DMH to assure appropriateness of placement and delivery of care to meet their special needs. Because of the fact that the number of such patients was deemed to be large and because the number of facilities involved were six or more, it was agreed that such reviews by DMH should begin at Lorraine Manor and continue apace throughout the other facilities as time and staff resources permitted.
3. That the Commissioner of DMH would make available a list of all mentally ill patients discharged from DMH facilities into SNF's and ICF's in the past three years.

Also, on August 6, 1979, DMH provided HCFA's Medicaid Bureau with a copy of their policy governing the discharge of mentally ill patients from DMH facilities into

SNF's. (Attachment A) On November 2, 1979, the Medicaid Bureau took exception to some of the elements included in this discharge policy. (Attachment B)

In order to discuss these differences more at length and to negotiate the remainder of the delivery of actions agreed upon at the meeting of July 18, 1979, a number of contacts and meetings were held with various State officials. As a result of these discussions, we were subsequently left with no assurance that the agreed upon actions discussed on July 18, 1979 would be taken.

With regards to the list of all mentally ill patients discharged from DMH facilities into SNF's and ICF's in the past three years which was not provided as agreed, we did obtain certain meaningful information included in the Commissioner of DMH's testimony before the Subcommittee on Nursing Homes of the Public Health Committee of the Connecticut General Assembly regarding nursing home utilization by his Department. As part of the testimony submitted for his appearance on October 24, 1979, a member of his staff made available to the Subcommittee the following information: during fiscal year 1978 (July 1, 1977—June 30, 1978) 851 patients were discharged from DMH facilities into nursing homes, the DMH facilities were identified, with the number of patients given by facility and the names of six nursing facilities were listed as receiving these patients: Lorraine Manor, East Hartford Convalescent Home, Meadows Convalescent Home, Middletown Haven Rest Home, Hillside Manor and Prospect Gardens. A comment is made in the Subcommittee document: "However, because of recent concern over their eligibility for Federal Medicaid reimbursement, the following nursing homes are no longer used for DMH discharges."

The Medicaid Bureau, analyzing its posture regarding this problem in Connecticut, considered the following facts. While it was subsequently found that Lorraine Manor was not in direct violation of Federal regulations as being

"primarily engaged" in the diagnosis and treatment of the mentally ill (51 percent rule), the large number (over 100) and the percentage (well over 40%) evidenced massive discharges of mentally ill patients in violation of the spirit, if not the intent of the regulations. In addition, other facilities might be exceeding the 51 percent rule and be in direct violation of Federal regulations based on the above-cited testimony given the Connecticut Subcommittee on Nursing Homes. It was decided that the Medicaid Bureau could not ignore this critical problem and that it would conduct reviews at other facilities. The initial facility selected for review was Middletown Haven Rest Home.

Scope of Review

The review of Middletown Haven Rest Home was initiated at the request of the Regional Medicaid Director and was made in accordance with the financial and compliance standards for governmental auditing. Our review of expenditures claimed for this facility covered the period January 1, 1977 through September 30, 1979, whereas, our review of patient records covered the period January 1, 1977 through December 18, 1979. The primary purpose of the review was to determine whether the facility is in fact an IMD as defined in 42 CFR 440.140(a)(2) and 42 CFR 435.1009(e) or an ICF as defined in the approved State plan.

In conducting this review, we researched applicable Federal laws, regulations, policy interpretations and State plan requirements in order to properly define an IMD. In addition, we obtained the services of a psychiatrist and psychiatric nurse to review patient records for the period January 1977 through December 18, 1979. Based on these reviews, we determined the percentage of mentally ill patients in relation to the total population of the facility. The facility's license and staffing procedures were also examined to determine the character of the institution. We

also reviewed Independent Professional Review reports at the State agency's Office of Medical Services and Medical Review Team Disability Determination Reports at the Middletown District Office.

We also reviewed Quarterly Statement of Expenditures to determine the payments made to Middletown Haven Rest Home for which Federal Financial Participation was claimed for the period January 1, 1977 through September 30, 1979. Additionally, we held discussions with the facility's owner, Administrator, and other staff members as well as with various State medical and financial personnel.

A nurse from the State agency acted as an observer during certain segments of our review of patient records at the facility.

RESULTS OF REVIEW

Our review showed that Middletown Haven Rest Home is an IMD which provides psychiatric services to individuals who are under and over 65 years of age. As a result, all of the amounts paid to this institution are not allowable for Federal Financial Participation as the State plan does not cover services to the mentally ill in IMD's (Attachment C). The unallowable expenditures amount to \$3,269,310 (Federal share \$1,634,655) and are identified in the following schedule:

Expenditures Claimed by the State Agency on Behalf of Medicaid Recipients Residing in Middletown Haven Rest Home

Quarter Ending	All Recipients		Recipients Between 21 and 65 Years of Age	
	Total Expenditures	Federal Share	Total Expenditures	Federal Share
3/31/77	\$ -0-	\$ -0-	\$ -0-	\$ -0-
6/30/77	91,169	45,584	39,534	19,766
9/30/77	114,817	57,409	66,232	33,116
12/31/77	175,841	87,520	115,787	57,894
3/31/78	163,758	81,879	113,660	56,830
6/30/78	221,262	110,631	161,805	80,902
9/30/78	281,382	140,691	201,337	100,669
12/31/78	690,954	345,477	500,989	250,405
3/31/79	529,244	264,622	370,443	105,221
6/30/79	527,792	263,896	365,700	182,850
9/30/79	473,891	236,946	338,789	169,395
	\$3,269,310	\$1,634,655	\$2,274,276	\$1,137,138

Although total expenditures have been deemed unallowable on the basis of State plan requirements, we cannot ignore the fact that they also include \$2,274,276 (Federal share \$1,137,138) that have been specifically precluded from Federal reimbursement because they apply to individuals between 21 and 65 years of age. Section 1905(a)(vi)(17)(B) of the Social Security Act specifically prohibits Federal Financial Participation for this age group and judging by the amounts included in the total claim it is evident that this Statute has not been considered in the computation of the State's claim.

The purpose of our review as previously stated was to determine whether in fact this facility was an IMD. In making this determination, it was essential to determine in accordance with Bureau Guidelines whether this facility is "primarily engaged" in the care and treatment of individu-

als with mental diseases and whether its "overall character" is that of an IMD within the meaning of the Statute. The detailed results of our determination are presented in the following sections.

Federal Regulations

Federal regulations define what constitutes an IMD. An IMD "means an institution that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such." 42 CFR 435.1009(e). This definition of an IMD applies to an ICF as well as a SNF.

Medicaid Bureau Guidelines

Based on the above citations HEW has developed criteria to determine what constitutes "primarily engaged" and the "overall character" of a facility in order to arrive at a determination that a facility is indeed an IMD. The determination that a given facility is an IMD will be based on a cumulative weighing of the following eight factors:

1. That a facility is licensed as a mental institution,
2. That it advertises or holds itself out as a mental institution,
3. That more than 50% of the patients have a disability in mental functioning,
4. That it is used by mental hospitals for alternative care,
5. That patients who may have entered a mental hospital are accepted directly from the community,
6. That the facility is in proximity to a State Mental Institution (within a 25 mile radius),

7. That the age distribution is uncharacteristic of nursing home patients, and
8. That the basis of Medicaid eligibility for patients under 65 is due to a mental disability, exclusive of services in an institution for mental disease.

These criteria are contained in instructions issued by the Medical Services Administration (the predecessor organization to the Medicaid Bureau before reorganization into the Health Care Financing Administration in 1977) which are Field State Information and Instruction Series 76-44, 76-97 and 76-156.

The criteria, in the judgment of the review team, were never intended to be all-inclusive. As a result, two new criteria will be discussed in addition to the eight that were promulgated by HEW. In addition, the team considered that each of the criteria did not carry equal weight. Taken alone, a high percentage of individuals in a facility having mental impairment is more persuasive for an IMD classification than the sole fact that the facility is within a 25 mile radius of a State mental institution. Further, the fact that a facility does not meet all criteria should not derogate from a valid conclusion if the evidence taken as a whole supports a reasonable finding that the facility is an IMD within the meaning of the Statute.

Review of Facility to Determine Compliance with Bureau Guidelines

1. Licensed as a mental institution

In the entrance interview with the administrative staff of the facility, the administrator indicated that while his facility is licensed as a Rest Home with Nursing Supervision, it meets the requirements of certification as an ICF and is so reimbursed by the Medicaid program. He pointed out that his license from the Department of Health specifies "authorization to care for persons with certain psychiatric

conditions." A copy of the annual licenses from January 1977 to December 31, 1980 are attached. (Attachment D)

The staff of the facility stated that not only is it identified in the license but that they view the facility as a psychiatric facility. Statements were made with regard to the patient population that it consisted mostly of mentally ill patients, for the most part transferred from Fairfield Hills Hospital, a State mental institution. Also, the statement was made that local hospitals have been advised of this specialty and will specifically refer patients with mental impairments. They also reported that the general public is aware of this specialty and refer to the facility in the same terms utilized for mental institutions. Other indications were given during the interview that supported the team's conviction that the facility administration regards its license seriously and viewed itself as a licensed facility for psychiatric conditions. These other indications follow as independent criteria because they can be either documented or are so evident and persuasive that they merit individual treatment.

In any case, both from looking at the license and judging the convictions of the staff, this facility meets the criteria of being licensed as a mental institution.

2. Advertises or holds itself out as a mental institution

The administrator was asked specifically whether the facility bought any advertising in which it was stated that the facility specialized in the care of patients with mental impairments. The reply was in the negative. He stated that at some time thought was given to make [sic] some statement of the sort in the yellow pages of the telephone directory. He was not sure whether they had done so or not. The advertisement in question was looked at and simply gave the name, address and telephone number of the facility.

In this connection, he stated that the facility does hold itself out to sources of referral as specializing in mental diseases. Fairfield Hills Hospital is constantly in touch with

him (prior to the freeze on patient discharges) to accept patients. They have a well-established process whereby he and his Director of Nursing review patient records to decide whether they will be accepted. In relation to this he produced a copy of the admission policy which he has furnished the facilities that submit patients for admission. (See attachment E) Besides Fairfield Hills, he holds meetings on a frequent basis with other facilities such as Connecticut Valley Hospital, the VA Hospital and Middlesex Hospital, to review patients for admission. The patients considered for admission from the above hospitals are usually mental patients.

As partial verification of the statements made above, a call was placed to Middlesex Hospital (located in Middletown) describing the need of care for a patient with a mental condition and asking for information on facilities giving such care. Middletown Haven Rest Home was named after some discussion about State institutions.

The judgment of the team is that Middletown Haven, while it does not advertise itself in the media as such, does advertise itself to sources of referral and does hold itself out as a facility specializing in the care of persons with mental diseases.

3. More than 50% of the patients have a disability in mental functioning

Of all the criteria considered indicative of a facility "primarily engaged," this is the one deemed most persuasive when documented. The psychiatrist on the review team designed and led the review of the data upon which determinations were made that patients in the facility were "individuals with mental diseases" as stated in the regulations.

The primary document for the review is the facility's log of all the patients admitted into the facility from January 1977 to December 18, 1979. There is a duplication of

numbers because some patients were admitted and discharged several times in that time span. A second document was secured which reports, to the Connecticut Department of Health, the patients in the facility within one reporting year. A third document consists of the claims paid by the Department of Income Maintenance at monthly intervals for the Medicaid eligible patients in the facility. From all of these lists, an unduplicated list of patients was compiled for which a determination of "mental illness" had to be made. The number of patients deemed to have been in the facility since January 1977 is 469.

The psychiatrist on the team reviewed the available data. He ran a test sample under his direction that followed the following instructions. He, the nurse and the program specialist on the team would review the same patients from the admission logs, reports to the Department of Health and patient records and arrive at individual determinations. The program specialist would only consider patients with obvious mental disabilities with the following criteria: the only diagnosis is a clearly mental diagnosis and the patient was previously a patient in a mental hospital. He and the psychiatric nurse would go beyond this criteria and review the complete record on the patient and consider all the criteria to include history, diagnosis, treatment (including medications), professional nurses notes, etc. It was intended that the same patient would be reviewed more than once from different records by the same reviewer and from the same record looked at by different reviewers. Of 74 records reviewed in the sample, all three reviewers arrived independently at the same determination. For the remaining 395 patients, it was then decided that the above process was valid and clear cases were to be decided by the program specialist and the remainder by the other two members with detailed and in-depth review of patient records. Where there was even the slightest possibility of a question, the case was referred to the psychiatrist for his in-depth review and final determination. The psychiatrist

reviewed a random number of clear determinations to confirm that a proper determination was made.

Of the 469 patients deemed to have been patients in the facility from January 1977 to December 18, 1979, 364 or 77% were found to have a mental illness in accordance with major mental disorders listed in ICF-8, DSM II and all major textbooks of psychiatry. (See consulting psychiatrist's report, Attachment F).

In view of the above, it is the finding of the team that this facility is "primarily engaged" within the meaning of the regulations as caring for persons, far in excess of 50%, with diagnoses of mental illness.

As additional confirmation, we refer to the findings of independent professional reviews (IPR) performed by State teams during the same period and reported under criteria #10 and the findings of the Medical Review Team reported under criteria #8.

4. Used by mental hospitals for alternative care

Every facility in Connecticut must submit each year an Annual Patient Roster to the Department of Health, the licensing agency. The roster, among other information, contains the date of admission, where the patient is admitted from, the diagnosis, the date of discharge and the destination upon discharge.

The facility rosters show that from January 1, 1977 through December 18, 1979 239 patients were admitted from three State mental institutions: Connecticut Valley Hospital, Fairfield Hills Hospital and Norwich State Hospital. This represents in excess of 50 percent of total admissions over the same period. Further, the roster for the period October 1, 1977 through September 30, 1978 shows that 167 were admitted from the three State facilities. Of the 167, 88 or 50% were discharged from the facility during the year. Of those 88 patients more than half, 56, were re-

turned to the mental institution whence they came. Of some significance is the length of stay of these patients in Middletown. The shortest stay was one day and the longest was thirteen months. More than 90 percent stayed less than eight months and nearly 70 percent stayed less than 3 months.

While 56 of the 88 patients discharged returned to the original institution whence they came, only 7 of the remaining 32 were returned to a community setting. The remainder were discharged to other institutional settings.

The above shows that the State mental institutions have utilized this facility as an alternative care setting by reason of the number of patients they have placed in the facility; [sic] by reason of the large percentage that have been returned to them and by the few that have been returned to community living.

It is the finding of the team that this criteria [sic] has been strongly met.

5. Admitted mental patients from the community that may otherwise have entered a mental hospital

We have indicated above that a large proportion of patients come from State mental institutions (167). Of the remaining patients with diagnoses of a major mental illness classification in the facility between October 1, 1977 and September 30, 1978, 42 came from a large variety of institutions (hospitals, SNFs, ICFs, residential facilities and private homes). These patients have diagnoses of a major mental illness classification similar to those admitted from State institutions. Of these, 14 come from Middlesex Hospital, the local hospital, mentioned in Criteria 2 of this section where this facility has held itself out as a mental facility. The remaining 28 come from ten other facilities throughout the State and New York. Four (4) came directly from their own home.

By reason of the considerable number of patients with mental disorders being admitted from private settings as well as the large number of community settings from whence they come, it is concluded that this facility cares for patients that otherwise might be admitted to mental institutions.

6. Proximity to a state mental institution

Middletown Haven Rest Home is within three miles of Connecticut Valley Hospital, a State mental institution. It is within forty miles of Fairfield Hills Hospital, another similar State facility, and a comparable distance from Norwich State Hospital in another direction.

Proximity is a relative thing. This criteria has defined proximity as a 25 miles [sic] radius. In a very compact State such as Connecticut, with a system of super highways that intersect the State in all directions, combined with the habits of a very mobile population, an additional fifteen miles would not be unreasonable as meeting the definition of proximity.

The fact is that these three facilities have discharged a large number of patients into Middletown Haven Rest Home. Indeed, Fairfield Hills, roughly forty miles away, has discharged into this facility at nearly a 2 to 1 ratio to the next-door facility, Connecticut Valley. During the period October 1, 1977 through September 30, 1978, the Annual Patient Roster mentioned earlier disclosed that 167 of the 356 patients or 47 percent admitted to the facility came from the three State Mental Institutions (Connecticut Valley—59 patients, Fairfield Hills—101 patients, Norwich State—7 patients).

The above data shows [sic] that from State mental hospitals alone, during this period, Middletown Haven has received nearly half of its patients.

The review team finds that while this criteria [sic] is not the most persuasive geographically viewed, it is amply demonstrated that this factor was operative in the growth of the patient population in this facility and the fact that it became primarily a population of patients with mental diseases.

7. Age distribution is uncharacteristic of nursing home patients

The administrator of the facility estimated that his patient population between the ages of 21 to 65 was probably around two-thirds.

Of the 469 patients admitted to the facility for the period January 1, 1977 through December 18, 1979, we found that 295 were over 21 and under 65, representing 64 percent of the patient population. National statistics have shown that the aged consume consistently the largest portion of the ICF services. HCFA's 1979 revised edition, "Data on the Medicaid Program", shows that the aged accounted for 63 percent of the Medicaid expenditures in ICFs. The remaining thirty-seven percent is distributed among the AFDC Adults, AFDC Children, the Blind and the Disabled which are the program categories in which the 21-65 Medicaid population would be found. This makes it clear that the distribution is exactly reversed and therefore, uncharacteristic in this facility. In addition, the average age of patients in long-term care facilities in the United States is 82.

Additional data collected in the review further confirm the presence of an uncharacteristically young population in what is deemed to be a long term care facility. One, in the section under criteria #3, our data collected from the annual patient rosters shows that 469 patients resided in the facility over less than a three-year period indicating that an unusually large number had significantly brief stays in the facility. In Criteria #4, the length of stays are [sic] seen to be unusually brief when they are examined

specifically. A high mobility of patients in and out of the facility confirms that presence of an uncharacteristically young population. Two, in the IPR performed by the State Team in June 1978 the general comment is made:

"Since the Team's last visit many new patients have been admitted to Middletown Haven. There appears to be a younger than usual patient population in this ICF."

The team, based on the above, finds that the patient population in this facility is uncharacteristic of those usually found in a nursing home.

8. Basis of Medicaid eligibility for patients under 65 is due to a mental disability exclusive of services in an institution for mental disease.

The only basis on which an individual can qualify for nursing care under Medicaid between the ages of 21 and 65 is if that individual is blind or disabled, exclusive of services in an institution for mental disease. Determinations of disability are made by the State agency's Medical Review Team.

There were 295 individuals between the ages of 21 and 65 who were patients at Middletown and for which Medicaid payments were made. Twenty individuals were selected at random. The case files were drawn by the staff at Middletown District Office. For this sample, only those cases were deemed disabled on the basis of a psychiatric finding if the primary or single diagnosis were a major category of mental disease. On the basis of this sample, 13 of the 20 individuals (65 percent) were found disabled on the basis of a psychiatric condition.

Since other parts of our review showed that nearly half of Middletown patients came directly from State mental institutions (Criteria #4) and 77 percent of the total patient population have a significant mental illness (Criteria #3), we believe that this sample is a reliable indicator.

The team finds that the group of patients between 21 and 65 are eligible for Medicaid on the basis of a mental illness.

9. Hires staff specialized in the care of the mentally ill

Middletown Haven, in keeping with its stated intent to treat the mentally ill, hires medical and other staff with specialized training and experience in the care of such disabilities.

The facility hires, on a contractual basis, three physicians to provide services to its patients. All three are psychiatrists. The contract entered into specifies the following:

1. That the psychiatrist be an active medical staff member,
2. That the psychiatrist come in at least weekly for consultation on patients, and
3. That the psychiatrist participate in in-service education programs for the staff.

Discussion with the facility's staff disclosed that the nurses and aides hired are usually selected on the basis of background and experience in psychiatric facilities. All have had some training and understand at the time of hiring that the patients are primarily mentally ill.

Even the non-medical staff, such as recreation and craft directors, maintenance and other support services, cafeteria workers and volunteers—all are informed at the time of hiring of the emphasis on psychiatric conditions and are selected on their ability to deal with this fact.

Each employee has participated in some in-service training designed to develop and support their ability to relate to the mentally ill. All have access to the psychiatrists on a one-to-one basis if any problems develop around the care of a particular patient. With regard to the nursing staff, a recent training session dealt with the management, dis-

persing and control of psychotropic drugs. There are in-house group therapy sessions held regularly in which both patients and staff members participate.

Our conclusion is that this facility very clearly hires and trains staff for the care and treatment of mental illnesses.

10. Independent professional reviews conducted by state teams report a preponderance of mental illness patients in facility

Four IPRs were conducted by State teams since the opening of this facility in January 1977. These reviews were conducted at approximately six-month intervals.

The patient assessment forms contain the diagnosis, medication and brief history of condition. In all cases of mental illness diagnosed, the history and medications are consistent with the diagnoses reported. The general comments on the entire facility administration often focus on drug control and management. The psychotropic drugs used, in relation to the size of the facility, suggests and supports [sic] the presence of a high percentage of mentally ill patients.

The diagnoses most frequently reported for the patients are:

- schizophrenia, chronic, undifferentiated
- simple schizophrenia
- paranoia
- psychotic depressive reaction
- depression psychosis
- acute dissociative reaction
- manic depressive psychosis
- catatonic schizophrenia
- alcoholism with acute brain syndrome

The general comments in the IPR reports refer frequently to the high incidence of psychiatric patients and recommendations often emphasize the need for increased group therapy sessions.

The number and percentage of patients with diagnoses of mental illness at the time of four IPRs are as follows:

Title XIX Patients			
Total Patient Occupancy	Total	No. With Mental Diagnosis	% of Total Patient Occupancy With Mental Diagnosis
56	51	31	55
154	149	89	58
172	166	114	60
177	172	119	67

The team finds that at the time of the IPRs the evidence supports the presence of patients with clearly-established mental illnesses in excess of 51 percent of the patient population.

SUMMARY

In summary, the team has determined that Middletown Haven Rest Home is an IMD within the framework of all applicable Federal laws, regulations, and guidelines. As such, this institution is primarily engaged in providing psychiatric services to residents with a mental illness.

Section 1905 (a)(vi)(14) and (16) of the Social Security Act permits the States the option to provide psychiatric services for individuals 65 and over and under 21 years of age and Section 1905(a)(vi)(17)(B) precludes these same services for those individuals that are between the ages of 21 and 65.

The State of Connecticut, however, has not elected to cover IMD services under its State Plan; therefore, all payments made to this facility by the State agency are ineligible for Federal matching. In addition, the State Agency's claim directly violated Section 1905(a)(vi)(17)(B) as no provision was made to eliminate the payments made on behalf of the patients between 21 and 65 years of age.

In our opinion, these deficiencies evolved because the State agency had not established procedures to properly identify those facilities which meet the definition of an IMD and to specifically identify the expenditures associated with these facilities for exclusion in its Quarterly Statement of Expenditures.

Recommendations and State Agency Comments

We recommend that the State agency:

1. Adjust the next Quarterly Statement of Expenditures (HCFA Form-64) by \$3,269,310 (Federal Share \$1,634,655) to reflect the total Federal financial participation applicable to Middletown Haven Rest Home for the period January 1, 1977 through September 30, 1979.
2. Exclude from future Quarterly Statement of Expenditures all payments to Middletown Haven Rest Home commencing with the quarter ended December 31, 1979, until such time as the State modifies its State plan to include IMD services. If the State modifies its State plan, procedures will need to be established to identify and exclude payments made on behalf of residents between 21 and 65 years of age.
3. Establish procedures to identify those facilities which meet the definition of an IMD.

State agency officials preferred not to make any official comments on the draft report. They indicated that they will continue to study the report and respond to it at a later date. (See APPENDIX)

ATTACHMENT A
STATE OF CONNECTICUT
Department of Mental Health

August 6, 1979

Regional Medicaid Director
 Medicaid Bureau
 Department of Health, Education,
 and Welfare, Region I
 J. F. Kennedy Federal Building
 Boston, Massachusetts 02203

Please find enclosed a copy of the Department of Mental Health policy regarding discharge and placement of patients from DMH facilities into skilled nursing facilities. This policy was promulgated last Friday in response to your request and as noted in Commissioner letter to you of August 2.

I would appreciate any thoughts or comments about the policy which you may have, and I look forward to working with you towards resolving the other difficulties that we have been discussing.

Sincerely yours,

Commissioner

Enclosure

STATE OF CONNECTICUT
Department of Mental Health

August 3, 1979

COMMISSIONER'S POLICY STATEMENT NO. 14
DISCHARGE AND PLACEMENT OF PATIENTS
FROM DMH FACILITIES INTO SKILLED NURSING
FACILITIES

The following principles will be observed around the discharge and placement of all DMH patients at any Skilled Nursing Facility:

1. The patient must no longer require hospital care.
2. Placement in a SNF must be deemed the least restrictive alternative for providing appropriate care to the specific patient.
3. The patient must require the services of a SNF in specific ways such as:
 - a. Patient has a chronic medical condition requiring continuing nursing observation and care.
 - b. Patient is in process of physical and brain deterioration and requires continuing and increasing nursing care.
 - c. Patient is convalescing from a medical/surgical illness and required [sic] continuing nursing care.
 - d. Patient has severe physical limitations requiring a contained environment and assistance with the vital functions of daily living and medications.
 - e. Patient has a chronic mental illness, not requiring hospitalization, but so disabling as to require continued nursing supervision, medication, and care in order to maintain physical safety and well-being.

- f. Patient is a fragile elderly person with a complex of geriatric problems requiring continuing nursing supervision and care.
 - g. Patient is physically or mentally incapable of moving with reasonable speed without assistance to a place of safety outside the building.
4. Placement in a SNF must be recommended and planned for in the patient's individual discharge plan as determined by the responsible treatment team.
 5. The individual patient's clinical condition and need for services must fit the specific SNF in terms of nursing services, ancillary services, environment, activities, and behavioral control. A part of this determination will be firsthand knowledge of the SNF by a person with responsibility for the placement to ascertain the specific fitness of the placement. The patient and/or family, as appropriate, will be oriented to possible specific placements, preferably by visit, and the patient and/or family will participate in the final selection and agree to the placement.
 6. Follow-up for appropriateness and adaptation will be done by placement personnel by visit within one month and otherwise as indicated.
 7. A patient placed in a SNF from a DMH facility will, if rehospitalization is required, be returned to the DMH facility from which placed, regardless of regional boundaries. Exceptions for compassionate or practical reasons may be made by the Superintendents involved.

Commissioner

ATTACHMENT B

HCFA

December 2, 1979

Department of Mental Health
90 Washington Street
Hartford, Connecticut 06615

This is to acknowledge receipt of your letter of October 1, 1979, in which you enclosed the report of the review of former Department of Mental Health patients at Lorraine Manor. The report is in partial fulfillment of the agreement we made at our meeting of July 18, 1979, that all the patients discharged from DMH facilities in the past three years would be evaluated for appropriateness of placement.

We also acknowledge receipt of the statement of Policy No. 14 which you developed at our request to govern discharges of DMH patients into skilled nursing facilities. We took some time to analyze this document in order to measure its implications against the requirements of all pertinent Federal regulations. Because of the role this statement of policy plays in the evaluation of patients for appropriateness of placement in SNFs it is important that we discuss both documents in this letter.

Our first difficulty with the policy statement comes up with Item 3 taken as a whole. We do not believe that the wording makes it clear enough that more than one item of need would normally apply to each patient and that all of them should be taken into account and found applicable or non-applicable prior to discharge.

With regard to the specific items listed from a. through g. under number 3, we have no problems with Items a. through e. and we find that these conform to generally accepted criteria for placement into skilled nursing facilities. Criteria [sic] f., however, describes an old person with the problem usually attendant upon old age. Taken alone, it would not qualify a patient for skilled care but rather for

long term care in an intermediate care facility. In a patient with a history and probably a continuing condition of mental illness we would hardly envision seeing criterion f. stand alone in any evaluation. This would suggest to us an old argument that we have already deemed unacceptable that the mental illness somehow ceases to become a factor of special care when the patient reaches the magic age of sixty-five. The last criterion listed as g. under item 3 is absolutely unacceptable as a criterion for placement in skilled nursing facilities. This is the wording of a provision of the Connecticut Public Health Code which we have found to be out of compliance with Federal regulations for skilled nursing facility level of care. This office has raised this issue officially and has found the State out of compliance requiring on-going negotiations to resolve the issue.

The second document is the report of the review of every mental health patient at Lorraine regarding which you invited my thoughts and comments. The format of the report makes it difficult for anyone not having access to the working papers to evaluate how decisions, regarding appropriateness of placements were reached and what supports the overall findings. Also, if our analysis is correct, the criteria utilized in the evaluation are the ones contained in your policy statement. While we agree that using those criteria was essentially appropriate, to the extent we disagree with some of them will probably account for corresponding differences in the way we view the results of the evaluation.

With these two prefacing statements in mind, we must express some difficulty with accepting the general findings. Looking at the bareboned documentation furnished, we find it difficult to understand the relatively small number of 3e's assigned by the Committee to a group of patients that other information available to me describes as psychotic with diagnoses of schizophrenia, dementia precox, etc. in much larger percentages. Secondly, we find that the

criteria f. and g. appears [sic] unduly frequently and would not support the appropriateness of placement into a skilled nursing facility, as we have said earlier. Yet, the Committee has found that more than 90 patients out of 109 have either been appropriately placed initially or were properly placed at the time of the review. We believe that this outcome raises serious questions as to the acceptability of the review for the purposes we had mutually intended.

Mindful that these questions cannot be satisfactorily resolved in a letter, I have directed my representative in Connecticut, to contact you in order to arrange a meeting with you and the Committee and to perform a review of the documentation for the Lorraine Manor evaluations. He will be accompanied in this review by a psychiatrist from our Public Health Service. The purpose will be to develop a better actual understanding of the issues and a reconciliation of our differences in viewpoint. It is my conviction that this is essential before further reviews are made in all the other facilities. It will be important that these issues be resolved as soon as possible and it is my expectation that you will assist them in every way possible. It is anticipated that this review can easily be accomplished within the space of two days.

The purpose of our working together is to enable the restoration at the earliest possible time of Federal funds now being withheld in an amount approaching \$1 million. What has been accomplished to date, while gratifying, is not nearly enough to permit me to restore those funds that are viewed as vital to the successful management of the Medicaid program in Connecticut.

It is incumbent on me, also, to make clear to you what remains to be done of the agreement we had reached at our meeting on July 18, 1979. You were to make available to me a list of patients discharged from DMH facilities into SNFs for the past three years, which has not yet been received. Since Mr. will be meeting with you shortly, you

can work out the details with him and make it available at that time.

Finally, you have agreed to review all DMH patients in other facilities. The pace of the reviews could become a real problem to the Department of Income Maintenance if they are not completed with more speed than the one done at Lorraine Manor. Would you inform me as soon as possible of the date you expect to complete the reviews so that I may give Commissioner ____ a tentative target date for resumption of Federal funds.

This letter, of necessity, has concentrated on areas of apparent differences. I would be remiss, however, if I did not express my appreciation for the significant efforts you have made to date to meet the Federal requirements. That continuing spirit of cooperation will assure success to the tasks that remain to be done.

Should you have any questions regarding this letter, you may call me or ____ at (617) 223-6881.

Sincerely yours,

Regional Medicaid Director

ATTACHMENT C

(1) Inpatient hospital services

☐ Provided
☐ No limitations
☐ With limitations*
☒ Not provided

☐ Provided
☐ No limitations
☐ With limitations
☒ Not provided

(2) Skilled nursing facility services

☐ Provided
☐ No limitations
☐ With limitations*
☒ Not provided

☐ Provided
☐ No limitations
☐ With limitations
☒ Not provided

(3) Intermediate care facility services

☐ Provided
☐ No limitations
☐ With limitations*
☒ Not provided

☐ Provided
☐ No limitations
☐ With limitations
☒ Not provided

4.b. Services for individuals age 65 or older in institutions for mental diseases

(1) Inpatient hospital services

☒ Provided
☐ No limitations
☐ With limitations
☐ Not provided

☒ Provided
☐ No limitations
☐ With limitations
☐ Not provided

(2) Skilled nursing facility services

☐ Provided
☐ No limitations
☐ With limitations*
☒ Not provided

☐ Provided
☐ No limitations
☐ With limitations
☒ Not provided

(3) Intermediate care facility services

☐ Provided
☐ No limitations
☒ With limitations
☒ Not provided

☐ Provided
☐ No limitations
☐ With limitations
☒ Not provided

*Description provided on attached sheet

ATTACHMENT C

34a

COPIES 277A-200-

ATTACHMENT DLicenseBEST HOME WITH NURSING SUPERVISION

In accordance with the provisions of Section 19-33 of the 1933 Revision of the General Statutes
 I, Middleton Haven Best Home of Middleton Connecticut,
 (Mr. Raymond C. F. A. M. A.)
 is hereby granted permission to maintain and operate a rest home with nursing supervision, known
 as Middleton Haven Best Home at 111 Church Street

in the City of MIDDLETOWN, Connecticut, with
 the Town of _____

Arnold Benson M.D., of Chester as Consulting Physician
 and Patricia Sanford, R.N. of Wethersfield as Resident Nurse in Charge

The maximum number of persons cared for shall not exceed 150 at any one time.
 This license expires Dec. 31, 1930, and may be revoked for cause at any time.
 Dated at Hartford, Connecticut, this 1st day of January, 1930
 No. 135-23 authorization to care for persons

With certain psychiatric conditions

Douglas S. Lloyd, M.D.

CONNECTICUT STATE DEPARTMENT OF HEALTH

Form 23-33

Commissioner of Health

ATTACHMENT D**Turner****REST HOME WITH NURSING SUPERVISION**

In accordance with the provisions of Section 19-13 of the 1953 Revision of the General Statutes
 Middletown Haven Rest Home _____ of _____ Connecticut,
 (Mr. Raymond C. Administrator)
 is hereby granted permission to maintain and operate a rest home with nursing supervision, known
 as Middletown Haven Rest Home _____ at 111 Church Street _____

in the City of _____
 Town of _____

Arnold Herman _____ M.D., of Chester _____ as Consulting Physician
 and Patricia Sandford, R.N., of Wethersfield _____ as Resident Nurse in Charge

The maximum number of persons cared for shall not exceed 180 at any one time.

This license expires Dec. 31, 1979, and may be revoked for cause at any time.

Dated at Hartford, Connecticut, this 1st day of January, 1979

No. 135-28

Authorization to care for persons
 with certain psychiatric conditions

CONNECTICUT STATE DEPARTMENT OF HEALTH
 Form 28-13

Douglas L. Lloyd, M.D.

Commissioner of Health

REC'D MEDICAID P
 BOSTON

JAN 21 '00

ATTACHMENT DLicenseBEST HOME WITH NURSING SUPERVISION

In accordance with the provisions of Section 15-33 of the 1953 Revision of the General Statutes
Middletown Haven Rest Home of Middletown, Connecticut,
 is hereby granted permission to maintain and operate a rest home with nursing supervision, known
 as Middletown Haven Rest Home at 111 Church Street

in the City of MIDDLETOWN, Connecticut, with
Louis Laballe, M.D., of Middletown as Consulting Physician
 and Mrs. Patricia Sanford, R.N. of Westhampton as Resident Nurse in Charge

The maximum number of persons cared for shall not exceed 180 at any one time.

This license expires Dec. 31, 1978 and may be revoked for cause at any time.

Dated at Hartford, Connecticut, this 1st day of January, 1978

No. 135-78

*Inc. in bed capacity - 2/3/78

Authorization to care for persons
 with certain psychiatric conditions

Douglas L. Lloyd, M.D.

Commissioner of Health

CONNECTICUT STATE DEPARTMENT OF HEALTH

ATTACHMENT DLicenseBEST HOME WITH NURSING SUPERVISION

In accordance with the provisions of Section 19-33 of the 1953 Revision of the General Statutes
Middletown Haven Rest Home of Middletown Connecticut
 (Dr. Raymond Lublin, Administrator)
 is hereby granted permission to maintain and operate a rest home with nursing supervision, known
 as Middletown Haven Rest Home at Middletown

in the City of MIDDLETOWN Connecticut, with
Louis LaBella M.D., of Middletown as Consulting Physician
 and Mrs. Patricia Sanford, R.N. of Wethersfield as Resident Nurse in Charge

The maximum number of persons cared for shall not exceed 120 at any one time.

This license expires Dec. 31, 19 78 and may be revoked for cause at any time.

Dated at Hartford, Connecticut, this 1st day of January, 19 78

No. 135-FH Authorization to care for persons
 with certain psychiatric conditions

Douglas L. Lloyd, M.D.

CONNECTICUT STATE DEPARTMENT OF HEALTH
 Form 25-12

Commissioner of Health

ATTACHMENT D**License****REST HOME WITH NURSING SUPERVISION**

In accordance with the provisions of Section 19-33 of the 1953 Revision of the General Statutes of the State of Connecticut, I, the Commissioner of the State Department of Health, do hereby certify that the following is a true and correct copy of the license as granted to the above named institution, and that the same is in full force and effect.

Middleton Haven Rest Home of Middleton, Connecticut, is a rest home with nursing supervision, known as Middleton Haven Rest Home at 111 Church Street in the City of Middleton, Connecticut, with the Town.

Dr. Louis LaBella, M.D., of Middleton, as Consulting Physician and Miss Patricia Sandford, of Manchester, Resident Nurse in Charge

The maximum number of persons cared for shall not exceed 120 at any one time. This license expires Dec 31, 1977 and may be renewed for cause at any time.

Dated at Hartford, Connecticut, this 1st day of January, 1977.

No. 135-28

*Increase in bed capacity 6/13/77

Authorization to care for persons with certain psychiatric conditions

Douglas L. Lloyd, M.D.

Commissioner of Health

CONNECTICUT STATE DEPARTMENT OF HEALTH
Form 13-19

ATTACHMENT DLicenseREST HOME WITH NURSING SUPERVISION

In accordance with the provisions of Section 19-53 of the 1953 Revision of the General Statutes
Middletown Haven Rest Home of Middletown Connecticut
 (Dr. Raymond D. Lillian, Administrator)
 is hereby granted permission to maintain and operate a rest home with nursing supervision, known
 as Middletown Haven Rest Home at 111 Church Street
 in the City of MIDDLETOWN Connecticut, with
Dr. Louis LaBella M.D., of Middletown as Consulting Physician
 and Mrs. Patricia Sandford, R.N. of Manchester as Resident Nurse in Charge

The maximum number of persons cared for shall not exceed 60 at any one time.
 This license expires December 31, 1977, and may be revoked for cause at any time.

Dated at Hartford, Connecticut, this 18th day of January, 1977

No. 135-RH
 Authorization to care for persons
 with certain psychiatric conditions

Douglas L. Lloyd, M.D.

CONNECTICUT STATE DEPARTMENT OF HEALTH
 Form RH-13

Commissioner of Health

ATTACHMENT E

ADMISSION POLICY

All admissions will be based on patients [sic] needs. All patients must be certified to be ambulatory and able to care for themselves. All admissions will be made without regard to race, color, creed or sex on a space available basis. The physician will be notified upon admission and will see the patient within 24 hours. All admissions will be accompanied by a W-10 (Inter agency Patient Referral Form) signed by Physician. No person suffering from Communicable Disease, Critically ill or acute mental disorders, maternity residents, acute drug addicts, acute alcoholics, or requiring 24 hour nursing care will be admitted.

Patients Rights

If after three attempts at obtaining the necessary signature on the Patient's Bill of Rights, the Administrator will sign for the patient and note the reason.

Patients Complaints and Grievance Procedure: 249.12(a)(ii)(c)

Any resident, their spouses, the public or employees of Middletown Haven Rest Home may register a complaint or grievance without threat of discharge or other reprisal. A resident wishing to air a complaint or grievance may go through the Resident's Council, through the Director of Nurses or through the Administrator. All complaints will be kept confidential.

The Residents [sic] Council is opened to all the residents and meets tentatively every first Thursday of the month. The council meeting is held directly after the council meets with the Administrator and all other heads of departments to answer questions posed by the residents from their previous month's meeting.

Complaints may be given in writing or verbal. [sic] A record of the complaint will be kept in a file in the Administrators [sic] office.

Requirements for Admission:

Residents shall be admitted only on referral from a responsible source. No resident may be admitted on an emergency basis except in the event of a major disaster, in which case the State Dept. of Health shall be notified at the earliest possible time.

Sufficient information must be received pertaining to resident's condition by the person responsible for resident's admission to determine if such person is eligible for a Rest Home with Nursing Supervision.

A. Prior to admission a written statement shall be obtained from a physician licensed to practice medicine and surgery in Connecticut, stating that the resident does not need twenty-four hour nursing care. This statement is kept on resident's chart at all times.

B. No person who is physically and mentally incapable of making his own way, without assistance to the place of safety outside of the building, shall be housed in the institution. If the resident uses assistance in walking—such as a cane, crutch, walker—it must be for security reasons and noted as such on the chart.

C. No resident shall be admitted if in need of twenty-four nursing care. Residents shall be transferred if they develop a need for twenty-four [sic] nursing service.

D. No person under 16 years of age shall be admitted to the institution.

E. All residents coming from a psychiatric hospital or mental retardation center must have a copy of a [sic] clinical and social summaries. In addition, those residents coming from a mental hospital or those with a psychiatric background must have [sic] written statement that they are not

dangerous to themselves [sic] or others, or property signed by a board certified psychiatrist.

F. All residents with contagious diseases, acute drug addicts, maternity residents, and acute mental disorders as well as residents who might need chronic or convalescent care will not be accepted for admission.

MEDICAL RESPONSIBILITIES AT TIME OF ADMISSION & DISCHARGE

A. Complete physical examination by physician within 24 hours, unless performed within 5 days prior to admission and a copy of such findings made available for the facility's charts and medical history.

B. Admission orders to be filled out in accordance with State laws and signed by physician. The orders must include the following information: medications, treatments, restorative services, diet and activities.

C. Prior to or on admission a written statement shall be obtained from a physician licensed to practice medicine and surgery in Connecticut, stating that the resident does not need twenty-four hour nursing care.

D. Before a resident can be discharged from the facility to home or to any other facility, there must be a discharge order from the resident's physician. In the case of an emergency transfer to a hospital, the discharge order may be given by the physician covering the facility on an emergency basis, if a resident wishes to leave the home without the consent of his physician he will be asked to sign a release of responsibility.

ATTACHMENT F

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service

DATE: January 3, 1980

To: Medicaid Program
Specialist

FROM: Psychiatrist Consultant, DoADAMHP

SUBJECT: Medicaid Sponsored Trips to Connecticut

Thank you for the opportunity to inspect Lorraine Manor on November 14-15, 1979 and Middletown Rest Haven, on December 17-18, 1979 with your Medicaid Team.

My observations and conclusions regarding *Lorraine Manor*:

An overwhelming majority of patients on the mental health floor in this SNF did have major diagnoses of mental illness, were appropriately placed in a setting substantially more restrictive than a state mental hospital, were undoubtedly receiving care of their many physical conditions superior to that received in a state hospital, but would benefit from more regular care from consulting psychiatrists to monitor the use of and need for psychotropic medication, and to monitor and evaluate the changing needs of patients for a movement to either more or less restrictive medical and psychiatric settings. A sample of ten charts was inspected randomly, and five of these ten patients were briefly interviewed. The facility was clean, well equipped and clearly superior clinically and more cost effective than a state mental hospital.

My observations and conclusions regarding *Middletown Rest Haven*:

All charts (52) from the patient population on the fourth floor were inspected and data collected on source of referral, diagnoses, medications, nursing

notes and documentation of continuing need for placement in this ICF. All additional charts for other current and former patients were also examined except for those cases where the facility's own patient log indicated a major or primary diagnosis of schizophrenia, manic-depressive illness, or personality disorder. All charts with diagnoses of alcoholism and organic brain syndrome were examined and counted as case of mental illness where the record indicated that the psychiatric causes, complications or sequelae of these disorders were a significant part of the patients [sic] ongoing need for ICF placement. Patient records were uniformly legible, complete, well organized and entirely adequate to permit a determination of the presence or absence of mental disease as a significant justification for ICF placement.

The overwhelming majority of both current and former patients have documented mental illness that is a substantial part of their need for ongoing ICF care. This conclusion would still be valid if the patients with primary diagnoses of alcoholism and organic brain disease were excluded from the totals. The justification for their inclusion is their appearance as major mental disorders in ICD-8, DSM II and all major textbooks of psychiatry, and the fact that the State of Connecticut treats this class of the mentally ill in its state mental hospitals in general, not specialized, care settings.

With the exception of perhaps 10 of the current patients, all those with significant mental illness were determined to be appropriately placed. Fifty percent of these, however, are only now placed appropriately because of the absence of sufficient boarding homes, day treatment facilities, half-way houses, community residences and other community based and community mental health center related, transitional living and chronic care resources in Connecticut. That is, this fifty percent would be better treated and more cost effectively cared for in a variety of other facilities, if they existed.

The vast majority of these ICF patients are receiving care superior to that offered by a state mental hospital.

This ICF is clean, well staffed, well administered and operating in fact as a much needed ICF/MH, though no such entity is formally recognized by current Connecticut laws or regulations or licensing procedures, or the State Medicaid Plan.

General Comment

In the deinstitutionalization game, the federal Medicaid, Medicare and PHS Offices, the state mental health and health authorities, the HSA's, CMHC's, State Mental Hospitals, general hospitals with psychiatric, alcohol or rehabilitation units, private psychiatric and detoxification facilities, and nursing and boarding home facilities, all de facto operate as a "system". The least controlled, least regulated and least responsive piece of this system are the nursing and boarding homes. Until federal and state law requires such homes to be responsible and responsive members of that "system" or to make it without public funds, the deinstitutionalization game will continue to be a shell game for private profit and inferior patient placement. Through the state plan approval mechanism, the federal Region I Offices of Medicaid and the PHS-DoADAMHP should be able to have an impact on this problem, which is by no means unique to Connecticut.

Recommendation

Consideration be given to joint consultation and to joint review of State Medicaid and Mental Health Plans by the federal Region I Medicaid Authority and the PHS Office of the RHA.

M.D., MPH

APPENDIX

STATE OF CONNECTICUT
Department of Income Maintenance

APRIL 18, 1980

ALFRED FUOROLI
REGIONAL COMMISSIONER
HEALTH, EDUCATION & WELFARE
HEALTH CARE FINANCING ADMINISTRATION
JOHN F. KENNEDY FEDERAL BUILDING
GOVERNMENT CENTER
BOSTON, MASSACHUSETTS 02203

Dear Mr. Fuoroli:

This letter is for the purpose of responding to your March 17th letter to Commissioner Maher which accompanied your draft report on Middletown Haven Rest Home. The department would prefer not to make any official comments on your draft report at this time. We will continue to study the report and expect to respond to it at a later time.

Very truly yours,

Stephen H. Press, Director
Medical Care Administration

SHP:pat

cc: Edward W. Maher
Commissioner

REPORT DISTRIBUTION

	No. of Copies
HCFA	
<i>Regional Office</i>	
Administrator	2
Deputy Administrator	1
Medicaid Director	8
HSQB Director	1
<i>Central Office</i>	
Director, Bureau of Program Policy	1
Director, Bureau of Program Operations	1
Director, Bureau of Program Operations, Office of Program Administration	1
<i>Other Regional Offices</i>	
Regional Medicaid Directors — Region II-X	1
GRANTEE	
Commissioner, Department of Income Maintenance State of Connecticut	2
Commissioner, Department of Mental Health State of Connecticut	1
OTHER PARTIES	
Principal Regional Official	1
HEW Audit Agency — Regional Office	1
HEW Audit Agency — Hartford Branch	1

APPENDIX B

Excerpts from the testimony of Margaret Lempitsky

UNITED STATES OF AMERICA

BEFORE THE HHS DEPARTMENTAL GRANT APPEALS BOARD

**STENOGRAPHIC TRANSCRIPT OF
HEARINGS**

IN THE MATTER OF:

"INSTITUTIONS FOR MENTAL DISEASES"

Docket Nos. 79-52-MN-HC

79-89-MN-HC

80-44-IL-HC

80-150-CT-HC

80-184-CA-HC

Place: Washington, D.C.

Date: April 22, 1981.

VOLUME: 1

PAGES: 1 thru 263

[126] the review teams that conduct utilization reviews and independent professional reviews in the facilities around Connecticut.

We are presenting Mrs. Lempitsky as someone with a program perspective on the IMD issue. We think it is important to present someone who comes at this from the perspective of having to implement the IMD policy on a day to day basis.

Direct Examination by Ms. Corwin:

Q. Mrs. Lempitsky, how long have you been aware of the IMD provision?

A. Since approximately mid-seventies.

Q. And you were aware there was a statutory provision and a published regulation on the subject?

A. Correct.

Q. And how has Connecticut perceived the IMD provision? What is excluded from Medicaid coverage under Connecticut's understanding?

A. Primarily we exclude the ages of 21 and 65, the state mental hospitals.

Q. How many state mental hospitals do you have in Connecticut?

A. Currently we have four.

[127] Q. And how many did you have during this period of the late 1970's?

A. Three.

MR. SETTLE: Of the late 1970's did you say?

MS. CORWIN: That is correct, just to—

MR. SETTLE: Yes.

MS. CORWIN: —put in perspective that there were three, but there are currently four.

BY MS. CORWIN: (Resuming)

Q. Are there any private facilities that you also do not cover because of the IMD provision?

A. Yes. We have I think it is eight accredited psychiatric hospitals in the state.

Q. And those are private facilities?

A. Private, yes.

Q. Are there any individuals for whom you provide coverage in those facilities?

A. Those that are 22 and under.

Q. Mrs. Lempitsky, in the audit report that was submitted in connection with the Middletown Haven disallowance there is a list of 10 criteria that were used to identify whether or not Middletown Haven was to be classified as

an IMD. When did you first see this list of criteria?

A. It was after—well, when a draft report came out

. . .

[129] not remember.

Q. There was also reference to a regional attorney's opinion I believe. I think Ms. Hathaway mentioned that there was something attached to audit reports, although I will note for the record note to Connecticut's audit report.

Had you ever seen something in the form of an opinion of a regional attorney interpreting the IMD provision?

A. No, I have not.

Q. When did you and others of the Department of Income Maintenance become aware that the regional office, the Federal regional people, were taking the position that it was not only state mental hospitals but also Intermediate Care Facilities and Skilled Nursing Facilities that could be classified as IMD's?

A. Roughly I would say around 1976 we had received verbal indications to that effect.

Q. Did you receive anything in writing?

A. Nothing that I can remember.

Q. What was your understanding of how the regional office thought one should go about identifying what was an IMD? Were there any elements that they transmitted to you?

A. Verbally they were—as I recall, they were looking retardation patients that were involved.

. . .

[146] Q. Can you approximate the percentage of cases that you looked at in which there were multiple diagnoses, more than one diagnosis?

A. In percentages?

Q. Just roughly.

A. I was looking in terms of the psychiatric as opposed to other writing factors, but I would have to say that—would you repeat it again?

Q. Let me rephrase it.

A. Okay.

Q. Would you say that more than half of the individuals had multiple diagnoses, more than one diagnosis?

A. I think that that is very fair.

Q. Were there individuals who had no psychiatric diagnosis at all?

A. There were some, yes.

Q. The audit report on Middletown Haven refers to the fact that a number of individuals whose records were looked at had formerly been in state mental hospitals. Did your review confirm that?

A. Definitely yes.

Q. Did you set out some of the examples of such individuals in the affidavit that you submitted with the brief that we filed?

[147] A. Yes. Yes, I did.

Q. And how did you—why did you set out those five examples in the affidavit? What was the purpose of those five examples?

A. The purpose was to show that there were patients there were psychiatric and other complicating factors, which may have overridden the psychiatric condition and therefore as far as this department was concerned would not have been classified as a psychiatric patient, but there [sic] reason for placement was other than psychiatric.

Q. Can you suggest, based on your knowledge and your responsibility for placement decisions and knowledge of reasons for placement, why it might be that someone who had originally been in a state mental hospital might then be transferred to an intermediate care facility?

A. Oh, the patient could have stabilized to the point where it would no longer be necessary for an acute psychiatric care. It could have been a burnt out case where there was no intensive treatment that was going to benefit the patient primarily.

Q. Would there be cases in which individuals had developed physical conditions while they were in state six months since the date it opened.

. . .

[150] Q. Why did you not visit Middletown Haven as a way to prepare for testimony in this hearing?

A. Well, disallowance came in after, and as a result of the disallowance and the Middletown Haven—the state decided because of the pressures brought about by the Federal Government that we would—what do I want to—what is the word I am looking for? We would—

Q. Would convert?

A. Convert Middletown Haven into an IMD by removing patients from that facility who did not belong there and having the institutions come under the jurisdiction of the Department of Mental Health.

Q. Does the facility now have solely mental patients?

A. That was arrangement, yes.

Q. Can you describe any differences that you are aware of between the facility as it existed during the period of the disallowance and the facility as it exists today?

A. It is my understanding from the administrator that they have provided a far greater degree of intensity, in terms of the services, the organization, coordination between the different disciplines, and the hospital—or excuse me, in the ICF's at Middletown Haven.

Q. When you say there is more intensity in the services, are you speaking about psychiatric services?

[151] A. Some of the psychiatric services they are having more group meetings, team meetings, involving patients. They have developed a concept now where each patient has a contact person to go to where there are particular problems, if a patient had a particular problem that he needed help with. The whole climate of the institution seems to have gone to much more of a psychiatric—maybe not an acute mental hospital—but has taken on totally psychiatric flavor.

Q. Do you know anything about the patterns of movement back and forth between the facility and a state mental hospital as it is now versus what it was during the period of the disallowance?

A. Studies at the facility done prior to the disallowance have shown I believe there was upwards to 30 percent or more recidivism rate to the state institution of psychiatric patients. Since they have adopted their new philosophy and their new programming and they have introduced it by floor, the rate has decreased to now where the first floor they have instituted a program that is a zero return rate.

Q. Let me develop for a moment your term recidivism. Are you talking about a rate at which a resident of the ICF would be returned to the state mental hospital?

[152] A. Yes, because of some acute incident or some situation where the facility could not treat that patient.

Q. Prior to the conversion of the facility then there was approximately a 30 percent return rate to the state mental hospital in the case of something like an acute incident, and now there is virtually no return to the state mental hospital?

A. That is what the facility has said, yes. That is the documentation.

Q. Let me ask you just one point I am not sure that I covered before. You described approximately eight private psychiatric facilities I believe. Did you describe anything

about their accreditation? I may have forgotten this, but if—

A. They are also accredited by the JCAH. As mental hospitals.

Q. As mental hospitals?

A. As mental hospitals.

Q. And those are facilities that you do not cover under your Medicaid program, is that right?

A. Right.

Q. With the exception of the under 22.

A. Under 22.

APPENDIX C

**Excerpts from the Testimony
of Lawrence W. Osborne**

**UNITED STATES OF AMERICA
BEFORE THE HHS DEPARTMENTAL GRANT APPEALS BOARD**

**STENOGRAPHIC TRANSCRIPT OF
HEARINGS
IN THE MATTER OF:
"INSTITUTIONS FOR MENTAL DISEASES"**

**Docket Nos. 79-52-MN-HC
79-89-MN-HC
80-44-IL-HC
80-150-CT-HC
80-184-CA-HC**

Place: Washington, D.C.

Date: April 23, 1981.

VOLUME: 2

PAGES: 264 thru 449

[309] Whereupon,

LAWRENCE W. OSBORNE

was called as a witness, and upon examination testified
as follows:

DIRECT EXAMINATION BY MR. ENG:

Q. Will you state your name?

A. Lawrence W. Osborne.

Q. What is your present job?

A. I am the Acting Director of the HCFA Regional 1
Boston Health Care—Health Standards and Quality Bureau.
My permanent position is the Director of the Division of
that bureau's survey and certification operation.

Q. And what was your previous job?

A. Prior to April 16, 1980, I was the Director of the Special Programs Unit in the Public Health Services Regional Office of the Division of Alcohol and Drug Abuse and Mental Health Administration.

Q. Now, you are an M.D.?

A. Yes.

Q. With a degree from where?

A. Cornell University Medical College.

Q. What year?

A. 1967.

[312] CHAIRMAN SETTLE: All right.

BY MR. ENG: (Resuming)

Q. Now, Dr. Osborne, what you did at the facility involved a number of intricate steps. How did you start?

A. We started by interviewing the administrator and the director of nursing services for Middletown Rest Haven, and —

Q. At some point did you have occasion to determine what kind of a medical staff the facility had?

A. Yes.

Q. In terms of permanent medical director or consultants?

A. The medical director was not a board eligible psychiatrist, but was a licensed general practitioner in Connecticut. The three medical consultants retained by the facility through contract, which we examined the contracts, were all board eligible, if not board certified psychiatrists.

Q. Did you verify that information with anyone at the facility?

A. Well, subsequently — actually yesterday afternoon — I called the administrator and again verified that they were

in fact at least board eligible psychiatrists — those three outside medical consultants.

[313]Q. Now, did you have occasion to review the — review any medical records at the facility?

A. Yes. We started — Ms. McGilvery and myself — by examining all the medical records regardless of diagnosis, regardless of source of referral — on the fourth floor.

Q. How many records?

A. That was 52 records.

Q. Now, did you evaluate those together or independently?

A. We evaluated them independently and then checked to see how many we agreed on in terms of who we could responsibly call in the category of mentally disturbed or being primarily placed there for reasons of their mental status.

All but three we agreed upon and very briefly, after observing the patients, discussing the record again in even greater depth, and in talking with the director of nurses who was very helpful, —

Q. You mean the director of nursing at the facility?

A. At the facility, yes. We agreed on those three very quickly.

Q. Now, the director of nursing at the facility, do you remember her name?

A. Yes. Mrs. Patricia Sanford.

[314] Q. Do you know whether she was familiar with the patients?

A. She was intimately familiar with all the patients. I was quite impressed with her knowledge of what was going on with each patient.

Q. And you are saying you discussed some of the cases with her?

A. Yes. We actually used her opinion throughout for I would say a very small—less than one percent of all the patients—where we had some questions about deciding one way or the other, based on the evidence in the medical records.

And in any case where she expressed any ambivalence about whether the person was there primarily from a mental disorder versus a physical disorder, we did not count that persons [sic] as mentally disordered.

Q. As an example of the kind that you might have excluded after consultation with the director of nursing, what kinds of cases would they include?

A. I think one example would be somebody with either no prior psychiatric history and hospitalizations, or somebody with a couple of acute non-chronic psychiatric problems—say one or two admissions for acute psychosis or depression that had been treated a number of years before with no intervening history of mental illness, but then five years prior to then—1979—they developed a series of strokes and were exhibiting some of the symptoms of organic brain disease.

We would not call that person mentally ill.

[315] Q. Now after you—oh, by the way, what—in going through the medical records on the fourth floor, did you determine, or were you able to determine, anything about the quality of the records and the quality of records in general at the facility?

A. Our procedure on the first 52 was to look at really all the elements in the medical record, including things like a discharge summary from hospitals, other nursing homes, the state psychiatric hospital from where the patient might have come, report from the person's private physician if

they were admitted directly from home or from some other community facility.

The list of admitting diagnoses, the physician's orders, the medication sheets, the nursing notes—We found nursing notes very helpful in terms of what kind of treatment and what kind of services the person needed, and what they were being provided, especially in cases of mixed or multiple diagnoses.

We read the physician's admitting medical examination, the initial write up and virtually all aspects of the medical chart.

[316] We also did observe and talk to patients and talk to other staff regarding patients other than the director of nursing.

Q. Did you compare the medical records with any other records to determine the accuracy of the facility records?

A. In my opinion, they were very excellent medical records. They were complete. They were up to date. They were legible—even some of the physicians' handwriting was mostly legible.

Q. Now, after that process—well, were there records that the facility maintained which were derived from the medical records?

A. Yes. The facility had a log of all patients.

Q. A patient log?

A. A patient log.

Q. Did you test the accuracy of the patient log?

A. Yes, we went to the patient log on the first 52 patients and determined that the log very responsibly captured the one, two, three, four diagnoses—the relevant diagnoses—the ones relevant to the patient's placement. Then we subsequently used the log as an initial screen for all other patients that had been there since 1977.

[317] And we began by automatically excluding all patients who were in the log who had only a diagnosis of physical disorder, and automatically excluding all those that only had a diagnosis of mental retardation.

Q. Can we back up just a moment? When you say that the patient logs were accurate in relationship to the medical records to the extent that you tested that, can you give us an idea of whether or not the patient logs listed one diagnosis, or more than one diagnosis and then to that degree whether or not they reflected accurately what the medical records had?

A. I felt they reflected accurately what was—what the patient was being treated or cared for that was significant. I didn't feel the logs excluded any mention of any disorder for which the person was being actively treated to the degree that that was the significant reason why they had to be placed at that intermediate care facility.

Q. Now, when you used the patient logs, did you determine whether or not there were cases that were clearly excluded or included in the category of mental disease?

A. Yes. I repeat. We automatically excluded the people with primary or single diagnoses of mental retardation, and people with one or more diagnosis of physical disorders only.

[318] We automatically included people who had primary or only had diagnoses of mental disorders—and when I say mental disorder, I mean we automatically included only those people with mental disorders like schizophrenia, manic depressive illness, personality disorder.

We did not automatically include people with diagnoses among which included organic brain syndrome, chronic brain syndrome [sic], senility or alcoholism.

Q. Can you tell us whether or not the director of nursing was familiar with what you were doing—that is, as you were doing it, or at some point?

A. She was very familiar and helpful and worked with us the whole time. She retrieved [sic] the charts as we asked for them.

Q. Did she make any indication concerning the kinds of diagnoses you were gleaning or classifications you were making?

A. No, only when we asked her.

Q. When you asked her?

A. When we asked her—this is how we have decided on this one, do you think we need to go see the patient, what is your view? This way or that way?

Q. So it was your view that there were some number of clear cases—that is, cases where there was little question?

[319] A. Absolutely. On the basis of the first 52—when we looked at all 52 records, and toured that floor, we were comfortable that we could include and exclude as I have just described.

Q. Now, after you went through the process of including or excluding the patients with the clear diagnoses, what did you do?

A. We looked at all other records—some over 200, I believe—that had mixed or multiple diagnoses. And all those that had diagnoses of alcoholism or organic brain syndrome [sic].

Q. You are referring to the medical records?

A. Medical records, yes. Then we went through each of those in as much detail as we felt we had to to make a decision as to whether the person's reason for placement there was primarily for purposes of a mental condition or disorder or set of symptoms as opposed to a physical disorder or condition or set of symptoms.

Q. Now, when you encountered diagnoses like alcoholism or organic brain syndrome or chronic brain syndrome, how did you handle those? Were they clear cases?

A. Most of them ended up being when you went through the chart in some detail. For example, if a person had been in a state psychiatric hospital for 10 or 20 years, and had a diagnosis of organic brain syndrome, and the feeling from the discharge summary from that state psychiatric hospital was that the person's—the reasons for the person's placement in a state psychiatric hospital as opposed to some other hospital or facility were the behavioral intellectual, emotional and self care problems that attend some people with organic brain syndrome, and these were the primary reasons why they needed to be in a place that provided psychiatric care—

[320] And then if that person had no other physical problems that by themselves would have necessitated the person's placement in an ICF environment as restricted as Middletown Haven is, I then called that person mentally ill.

Q. You are saying—let me see if I understand—If you ran across a diagnosis like alcoholism or organic brain syndrome or those in particular, did you automatically included them in one category or another just on the basis of the single entry or diagnosis?

A. No. We looked at the chart in as much depth as we felt we had to. And [sic] example would be somebody who, for instance, would have a diagnosis at the time we looked at the chart of residual schizophrenia and some other disorders diabetes, high blood pressure—

[321] If that person had also been in a state mental hospital for a number of years and had been there and been treated for the psychiatric symptoms of schizophrenia, and if the nursing notes and the admission work up indicated that there was some residual impairment of mental status in terms of that person's ability to care for himself, make judgments—

And if those impairments resulting from residual or from burning out or burnt out schizophrenia were the major

reason for the person's needing that restricted environment, I called the person mentally ill.

Q. That raises another question. For patients—all patients indicating a history of prior psychiatric hospitalization, did you automatically categorize them either way?

A. No.

Q. What did you do?

A. If they had only on the facility's log—only an admitting diagnosis of schizophrenia, personality disorder, paranoia and so on, and they also had a long history of state psychiatric hospitalization, and had come directly from the state psychiatric hospital, then we did automatically include those people.

I can say for people with the chronic mental disorder—the history of it—and who had some physical problems also—I mentioned diabetes, high blood pressure—uninary [sic] tract infections or chronic obstructive pulmonary disease—I did satisfy myself that the reason—that the physical problems alone would not have necessitated their placement in Middletown Haven Rest Home.

[322] If they only had the physical problems and not the residual schizophrenia or the personality disorder, the behavior disorder, they wouldn't have had to be there, they could have probably been at home or in some other facility and be taken care of by a visiting nurse.

I satisfied myself that there were no ongoing mental problems—[witness corrects himself] physical problems, that were contributing to the person's impaired mental status. If there was kidney failure or liver failure, the facility was quite good enough to know that through periodic laboratory inspections and the quality of nursing care.

The persons who was [sic] being impaired mentally for some new physical reason would not have been appropriately placed. They would have needed at least a SNC level of care of perhaps a hospital.

Q. Did you say that you had observed some patients?

A. Yes.

Q. Did you use some kind of criteria to determine when you needed to do that?

[323] A. I did not a formal mental status examination on any patient. [sic] I talked to some of them to satisfy myself that there was—by observing them—some obvious behavior or mental impairment that was ongoing and that probably was a reason—if I excluded any physical from the review of the chart—probably the major reason why they needed that level of care or treatment in that kind of restricted environment.

Q. You mean in cases where you felt the record wasn't clear or where you couldn't make a determination—

A. Or, again, to just double check myself that the records were credible. I felt the records in general were very, very credible with respect to my ability to understand what had gone on with the patient and what was going on with the patient now.

I never would use a record as the basis for my treating a patient myself. I would obviously examine him. But for purposes of understanding what was going on with the patient, I felt there was a high degree of credibility in the records.

Q. Now, you indicated, I think—well, I think you indicated that persons having mental disease can also develop physical problems? Can you describe that process

* * *

[325] But from an administrative point of view, from what I saw in Middletown Haven Rest Home in Connecticut, it is absolutely essential for the protection of patient care to make some distinction, especially in the younger age group, which the population of Middletown represented.

That people be placed in SNC and ICFs who have primary or secondary—who have some ongoing mental problem—receive not just care, but some active treatment. And I have no assurance—I know that that is not happening in a number of other nursing homes in Connecticut.

Prospect Gardens was mentioned as one of the six into which a large number of patients from state psychiatric hospitals were placed. I am in the process of terminating that nursing home. It is no question in my mind—I hope I don't because I hope there is a change in ownership—

There is no question in my mind that those patients placed in Prospect Gardens received actually better care for both their medical and mental and physical problems in a state psychiatric hospital than they have at the Prospect Gardens Nursing Home.

Q. What about Middletown?

A. At least from an administrative point of view, there needs to be some protection so we have assurance that people with whatever residual or primary mental illness placed in these facilities are getting the treatment.

[326] They were beginning to at Middletown Haven Rest Home. It was an excellent facility. They were clearly getting better care than they would have had in the state psychiatric hospitals. I wish they were all like Middletown Haven.

Q. Another category that might be considered difficult—what did you do when you ran across a case of cerebral vascular accident? Were they counted automatically as one or the other?

A. If there was no other psychiatric history or diagnosis, they were automatically called physical.

Q. They were called as having no mental illness?

A. They were called as being physically ill even though they may exhibit some of the same behavior patterns as

other people I called mentally ill in the institution. In that sense I felt we were quite conservative in our approach by not automatically excluding everybody who would have been called mentally ill because they had a major diagnosis that fell into ICD-9 or DMS-3 in the mentally disordered category.

For some of the same reasons, both conservative with respect to making the determination for this case, and also conservative for some of the reasons Dr. Taylor mentioned yesterday of not wishing to label people unfairly.

[327] Q. Well, when you say conservative in terms of your—could you compare your approach in the way you handled cases like alcoholism and organic brain syndrome and the standards in the ICD or the DSM?

A. I feel quite comfortable with how we approached these decisions, considering how they are both labeled in those two diagnostic standards of criteria, and also for purposes of counting up numbers of people in one category or another, which we unfortunately had to do for purposes—the larger purposes of assuring that Connecticut provides active treatment for these people if they are placed in long term care facilities.

Q. Now, the results of your review were described in the official report?

A. Yes. Attachment F. I might also say with respect to the two categories of people with alcoholism and organic brain syndrome, that on the basis of just pure numbers alone, we automatically excluded people with those diagnoses, the facility would still have been over 50 percent with mentally ill from other categories.

Q. So as reflected in the report, based on the kind of evaluation you made, the overwhelming majority of patients were—

[328] A. Both by virtue of numbers and by virtue of the overall character of the facility—the way the staff talked

about the kinds of treatment they provided, the kinds of facility they felt they were—and they were proud of it—and with a great deal of deserve.

The character of the consulting medical staff and the kinds of therapies or care that were going on—group therapy—the consulting psychiatrists—And I might say the group therapy was ordered by the physicians as an integral part of an active treatment program.

They might have had certain behavioral—goals for behavioral change, certain kinds of psychotropic medicines, but that is not necessary for counting something as active or responsible treatment for somebody with mental symptoms. Programs to do with the community and do part time work in a sheltered workshop was one—the sheltered workshop equivalent, I should say, on the main street of Middletown with some of the local commercial operations there that were being responsive to the needs of the patients.

And it was one—all these various parts merged together were integrated as a part of the treatment program, ordered and signed by the psychiatrists.

Q. Now, aside from the fact that you found—that is that you made a determination about the number of patients or the percentage of patients having mental disease in the facility, did you make any other observations or discuss any other matters while you were there in terms of the facility.

[329] A. Well, it was clear to me as a general impression that it was overwhelmingly and beyond any reasonable doubt for many, many reasons—mostly from the character of the medical records and my observations—discussion with staff and observations of patients. It was very primarily an institution for mental disease.

And they were beginning to provide the kinds of treatment that the character of their population required, and

that was very heartening. I was very pleased yesterday to hear that subsequently Connecticut calls it an institution for mental disease and has expanded the treatment such that—and I think it is very telling that their recidivism rate back to the state hospital has almost gone down to zero.

That tells you the kind of people in that institution were the kind that could both through treatment, not move backwards lot a lot of them were ready to move forward. In my judgment, about half the people in Middletown Rest Haven when I saw it could have been placed in other even less restricted environments.

And I only said that they were appropriately placed because Connecticut doesn't have the other kinds of facilities available to them.

[330] Q. Now, I guess because of the way the law is written in terms of covered services, there is an issue in the case about whether it is proper to focus on diagnoses of individual patients or whether it is necessary to focus on the facilities' services—the kinds of care and treatment available and given to the patients.

Do you feel that there is any relationship between diagnosis and services?

A. I certainly do. I feel there should be if there is not. I felt there was at this facility. However, we did not just focus on diagnosis. We did look at the evidence in the medical record and also by observing the facility—what kinds of services were being provided.

Q. Now, if a facility were not concerned with diagnosis, could it provide the kind of care that the patients need?

A. Certainly the answer to that is, No—certainly for the population of patients that I saw at Middletown Haven Rest Home. It might be argued that if diagnosis isn't important, the services probably aren't medical in character.

If diagnosis isn't a part of the spectrum of an evaluation—diagnosis and treatment, it might be argued that the facility is being—the services being provided were pure care of a social maintenance nature and not medical.

[331] Q. We have had a lot of discussion about the meaning of diagnosis. Now, would you say the federal review team—not necessarily yours, but any one—would actually be diagnosing patients or are they doing something else?

A. Hopefully they would not pretend to diagnose by looking at the piece of paper. I think you have to differentiate between being able to understand—have enough credibility in the medical record—to understand what is going on from it versus you, yourself treating.

I don't think non-medical or non-nursing auditors would be able to have necessarily the same kind of credibility that I was able to have concerning the medical records. But if you assume that they are accurate and of reasonable quality, they do give you, I think, an accurate understanding of what is being treated.

And I think you can make a judgment as to what the primary reason for the person's being placed there is in terms of physical impairments versus mental impairments, yet leaving the issue aside as to what caused the mental impairment.

Q. So when you classify patients, or when any team would classify patients, as either mentally ill or not, you are taking into account more than just diagnosis? You are saying also—

[332] A. We certainly did.

Q. Yes. What kinds of factors—

A. Everything in the medical record—things pertaining to the services actually being given and evidence in the chart of—

Q. So there is a difference between the concept of—at least as it could be understood—the concept of making a diagnosis and your determination of whether or not someone is mentally ill?

In other words, to make the diagnosis—well, let's put it this way. I guess the record contains diagnoses, but when you make your decision to classify someone as mentally ill, you do more than just look at the diagnosis?

A. I did not exclusively look at the diagnosis except in those cases where on the basis of the law, and the validity check that I did on the law—I included/excluded those categories that I previously discussed.

Q. Were you concerned with the kind of treatment or the reasons for having the person in the facility?

A. Absolutely.

Q. And that is part of the classification process?

A. It was for us.

[333] Q. There has also been some discussion about—as I understand it—a distinction between a psychiatric disorder and a neurological disorder. Is it really one or the other? That is, taking cases of neurological disorder, would you consider all or some of those patients having these—having neurological disorder—as being mentally ill or having mental disease?

A. Well, I did again in, for instance, the case of the long-standing organic brain syndrome problem that had been treated for years and years in a state psychiatric hospital. As was mentioned yesterday, those problems have to do with the actual loss of brain cell tissue through a number of different processes. Just aging is one.

Q. What happens to treatment—

A. Well, there is no treatment. We have not learned

yet how to regenerate brain cells, and so the actual treatment for the cause of that—that neurological condition—doesn't exist unfortunately for many sub-types of organic brain disease.

However, when the symptoms are—when the symptoms are primarily psychiatric because of the emotional judgment, intellectual, behavioral components of them—I call the person mentally ill by virtue of what he exhibited that needed to be treated, on the one hand, and what the facility was providing him on the other—providing him through the use of psychiatrists, as opposed to neurologists.

[334] There was no consulting neurologist on the staff at Middletown Haven Rest Home, although I am sure that when neurological services had been needed, they would have been sought in local hospitals—private practice groups.

Q. Now, another issue—well, I should say an argument that Connecticut has made is that Middletown Haven rendered the types of services that are provided by a typical ICF. Do you agree with that or disagree?

A. I would like to think that the range of services and the staffing pattern—the quality and quantity that they had—represented a typical ICF. I know that is not true in New England. Because there are a lot of mentally ill—well, they are only 10 percent or 15 percent—those patients, if they are there, need some treatment.

Our regulations have trouble going after those kinds of problems, given our current set of regulations. Middletown Rest Haven, I felt, was functioning essentially as an ICFMH, which doesn't exist. It is not recognized, but they exist de facto, and the 50 percent rule—again I don't care if there are five percent people that need some specialized treatment—they should be getting it.

ICFMH equivalent to the ICFMR—We had a handle

. . .

[343] But the mental condition—the mental impairment—the behavioral problem did.

CHAIRMAN SETTLE: May I just ask a question about that? Some of the states have pointed out that a person like that might need some support—some passive care, but might not need to intensity of services that one would normally associate with a state mental hospital.

Do you find that to be the case based on the document you have in front of you?

THE WITNESS: I would think so, but with the caveat that I think this person needed the kind of active psychiatric treatment he was getting here through the program. Passive—I don't associate myself with passive care. I don't think this person had been given up on. I think the reason why he was placed there was that he probably got even more active treatment there than he would have at the psychiatric hospital.

And he was a potential candidate to move even to a less restricted environment after being treated in this ICF. I can't absolutely, certainly answer your question because I don't have his whole medical record in front of me to go through and refresh exactly what I did in this case.

But I can give you an idea of why, I think, I made some of the decisions I did.

. . .

[348] such a facility be certified for participation in the Medicaid program?

A. Again, if we were all clear on the exact definitions of what we meant by those things, I would say, No, it would not be.

Q. You mentioned that you talked with the staff at the facility at Middletown Haven. Can you tell me how the staff characterized the facility?

A. They felt that they specialized in treatment of people with primarily mental disorders. They specialized in it. The facility was primarily geared to it. They hired staff with that kind of background and interests, and they were proud of it.

And I say, deservedly so.

MR. ENG: No further questions.

CHAIRMAN SETTLE: Mr. Miller?

CROSS EXAMINATION

BY MR. MILLER:

Q. Dr. Osborne, from your last answer and a number of other comments, I have the impression that you have a high opinion of Middletown Haven, at least as of the time that you visited it?

A. Comparatively, yes, I would say a high rating compared to other ICFs that were treating people with these kinds of conditions.

[349] Q. In Connecticut or throughout New England?

A. Throughout, but also in Connecticut.

Q. You were asked a question by Mr. Eng that I didn't quite understand your response. He asked you if this Middletown Haven at the time you visited it, was like a typical ICF, and I am not quite sure of your answer to that questions.

Could you tell me what—

A. I equivocated. I didn't equivocate—I think it is more complicated than that. I would say it was typical of what an ideal ICF that has some mentally disturbed patients should have. Far too many of them don't. So, it is typical of what the ideal should be under the current law.

It is not typical of—especially many others in Connecticut with respect to its staffing pattern. I would say that it

is sort of on its way to becoming something that it isn't now through some of the additional staffing changes and programming changes they have taken when they decided they wanted to become an IMD.

Q. I want to come to that in a second, but at the moment I just [sic] focusing on what it was at the time you visited it, and I think what you said was that it was among the better ICFs in your experience. Right?

[350] A. Absolutely.

Q. In your review of the facility, you—did you or did you not go to Middletown Haven with the view toward reviewing the type of services which were provided?

A. Yes, we did.

Q. You gave some discussion about that this morning. Could you—are you in a position, based on your review there, to summarize the type of services provided the patient population at Middletown Haven?

A. I think so.

Q. I would appreciate it if you could.

A. There were all manner of nursing services appropriate for an ICF. That was all there. On the service side, I would characterize it as responsive to the mentally ill. There were both direct and indirect services—direct services in terms of qualified staff counselling with patients on behavior problems, patient groups being run, activities designed for patients.

I saw one group of relatively young people going out for an activity in the community together. There was design for part of their treatment program. Indirect services in the sense that psychiatrists both for in-service staff education and for enhancing quality of care of patients were having regular group sessions with staff on the various wards.

[351] An additional reason for that is to [sic] that they were concerned with building a milieu [sic]—

Q. Just a minute. The staff was having group sessions with the medical staff, is that what you said?

A. Yes. Consulting psychiatrists were spending some time with staff in troupes [sic].

Q. Thank you. I didn't mean to interrupt you.

A. Another purpose for that is that a team working together on a ward can function, and functioning as a team, can deal with some behavior problems, and that is very characteristic of an IMD—a programming method—on the way toward milieu [sic] therapy.

Q. Incidentally, these psychiatrists that you refer to—the three consulting psychiatrists—do you happen to know the amount of time they spent at the time at Middletown Haven?

A. My impression was that it was too little for the problems the population had, but I was quite tickled to see there was any at all.

Q. Would you think about one day a week would have been approximately what they were doing?

A. I can't recall. I think it was something like a week apiece, but I can't swear to it. My impression was it was too little for the patients' needs, but it was far more than was being provided for that kind of patient in many other ICFs, and I was pleased with that.

[352] Q. If you had an ICF that focused on the treatment of people with say cerebral palsy, is that a ridiculous assumption [sic] or could there be such a facility?

A. I think that is relatively ridiculous. Cerebral palsy is a wide range of those mental, psychiatric, neurological and physical conditions.

Q. How about epilepsy [sic]?

A. My feeling is that is awful ridiculous and that it would not make sense to "concentrate" with the word used yesterday, those people because there is not a special need.

Q. I am looking for some condition that would warrant some specialized treatment. You could pick an example of your own. How about people with heart conditions or perhaps people who are not ambulatory?

A. I wouldn't say so. I would rather group people regardless of diagnostic categories—based on their need, and if their needs, however, rather similar in terms of needs for psychiatric programming—whether they are cerebral palsy or whether they have organic brain syndrome, I think the advantages of some concentration for the quality

. . .

[361] being provided. I didn't see anything in the audit report that discussed the services at Middletown Haven provided. I may have overlooked that.

Q. Are you familiar with the audit report?

A. Yes, I am.

Q. The portions that I read at all—I saw the discussion of the patient characteristics, but I do not recall any discussion of the services being provided to them. Do you know why that was omitted from the report?

A. Well, in our methodology, I think it is explicit that we looked over some 200 charts of all patients that we had any questions about, and in looking at a chart in depth and all the various items and information I mentioned earlier, what you are looking for is the services.

Doctors' orders, medication records, nursing notes—the medical record is a record of, obviously, not just the diagnosis, but also the ongoing record of services provided to that patient and documentation of the patient's response to those services.

Q. One of the criteria discussed in the audit report was the age breakdown of the population at Middletown Haven compared to other ICFs. You haven't testified on that this morning, but are you familiar with that aspect of the report?

. . .

[370] Q. Can they?

A. They can, and I think probably some do. I would say I don't think they do it in the integrated fashion of a complete treatment program targeted for an individual person with a psychiatric oversight, as was occurring in Middletown Haven.

MR. SEIPLE: No further questions.

CHAIRMAN SETTLE: Let me ask a question of Mr. Eng, or perhaps you know. In the other three states, were those reviews conducted with the assistance of psychiatrist, or is it only Connecticut that we have a psychiatrist involved?

MS. HATHAWAY: It is my belief that only Connecticut had a psychiatrist. California had an audit team, and I believe in all the remaining states, it was Medicaid audit teams that did the work.

CHAIRMAN SETTLE: Mr. Miller, do you want to ask more questions, or shall I go to another state?

MR. MILLER: I don't think I have any more.

CHAIRMAN SETTLE: All right. Minnesota—Mr. Held?

MR. HELD: Yes. Perhaps I could just sit up here?

CHAIRMAN SETTLE: Sure.

. . .

[401] an ICF if it merely provided custodial care. Is that correct?

A. Well, that is first and foremost my professional opinion. I would go back and read the regulations and have my attorney and me debate as to exactly whether the regulations require that or not. For the kinds of people I saw Middletown Haven, it would be dangerous and abhorrent if anything less than medical treatment, some active treatment—

Q. I was wondering if you could take a few minutes to describe the type of treatment that you found at Middletown Haven and what you would ordinarily expect to find at at [sic] ICF that was not an IMD.

A. I don't think that the typical ICF in New England you would find any psychiatrists, even in the consulting capacity. Usually you wouldn't, I think. You would find other categories of medical doctors. You would not find staff trained or interested in coping [sic] with the problems of the mentally ill.

You would not find psychiatrists aside from their actually seeing and treating patients, you would not find them running groups or nursing—groups of nurses on individual wards. You would not find psychiatrists engaged in one to one psychotherapy or one to one re-evaluation of patients.

[402] You would not find the kind of patient therapy groups that my understanding is were going on at Middletown Haven or just about to—planned because of the recognized need. And I don't think in—this is to a lesser extent—you would find the kind of recreational activity program targeted to groups of patients with similar kinds of growth potential and needs that you found at Middletown Haven.

I am sure you do find some of that at other ICFs. I don't know first hand. Those are some of the things that I think—and I think what you would find maybe overly active treatment in the use and sometimes the abuse of psychotropic medicines in other ICFs, which was happily absent at Middletown Haven.

Q. If you can also briefly talk about the services that you would expect a state mental hospital to provide as compared to what you found at Middletown Haven.

A. It is hard to answer that one because there is now a very wide range of capability—the ability to actively treat in state psychiatric hospitals. If there is an industry norm, I would be hard pressed to say what it is.

Q. Would there be anything that you could point to that might distinguish the services or the treatment of Middletown Haven from those provided by a state mental hospital?

[403] A. Well, the old typical and hopefully fast-fading from the scene image of the state psychiatric hospital, I frankly would not find much more than you would find at Middletown Haven. I can't speak for the three, four, five whatever it was psychiatric hospitals in Connecticut personally.

My impression is that there has been some considerable movement in their capability to treat—improvement—but I really couldn't answer that piece.

MS. FORD: Thank you.

THE WITNESS: As I pointed out in the attachment, I think in some ways an ICF like Middletown is a more restricted environment than a state hospital in that you don't have the gymnasiums and the pool halls and the floating lawns and the multiple building and so forth.

But on the other hand, I think there you could argue that there probably is more active treatment that is appropriate to patients' needs.

MS. FORD: Thank you very much.

MR. KAUFMAN: What is your opinion of the agency's criteria for identifying ICDs?

THE WITNESS: Well, as I use them or modified them I think they are adequate enough to do what I think is very

important—mainly to be able if not for patient needs, for administrative needs to say is this facility providing the services that the population it serves has.

[404] And we need some assurance about that. And in the absence of better regulations, which may mean fewer regulations and more people who can go out and take a look, I think it is awfully important to use that IMD concept because it is one handle we have on situations like Prospect Gardens in Connecticut.

MR. KAUFMAN: It sounded to me like you did significantly modify them in your own approach. Am I correct?

THE WITNESS: Which ones are you referring to?

MR. KAUFMAN: Of the eight that were listed—The list is at the bottom of page 13—

THE WITNESS: I think I was answering—thinking you were asking me about the criteria for actually looking at individual patients to say whether they were or were not—which is on this letter from SRS Regional Commissioner of the ABCD.

But in answer to the question about the 10—I think taken in aggregate, with the kind of review at Middletown Haven, I think they are adequate. I would be happy, I think, to do a little more thinking about that and give you a fuller maybe more thoughtful response than I could. . . .

APPENDIX D

FY-76-44

DEPARTMENT OF HEALTH,
EDUCATION, AND WELFARE
SOCIAL AND REHABILITATION SERVICE
WASHINGTON, D.C. 20201

November 7, 1975

MEDICAL SERVICES
ADMINISTRATION

INSTRUCTION—PS

TO: SRS Regional Commissioners

SUBJECT: *FIELD STAFF INFORMATION AND INSTRUCTION SERIES*: FY-76-44 Federal Financial Participation in Payments for Care in Institutions for Mental Diseases

As you know, Federal matching under Medicaid is available under certain conditions at State option for payments for inpatient hospital services, skilled nursing facility services and intermediate care facility services for individuals 65 years of age or over in an institution for mental diseases and for inpatient psychiatric hospital services for individuals under 21. Otherwise Federal matching is expressly excluded by the Social Security Act from any payment for care or services provided to individuals in institutions for mental diseases. It has come to our attention through recent Regional Office findings and a GAO study by the Mental Health Task Force that this has been ignored, that Medicaid payments have been made for individuals between 21 and 65 in institutions for mental diseases and that Federal financial participation has been claimed improperly. To the extent that this has been or is being done there is a serious potential for sizeable audit exceptions.

The pertinent regulations are contained in 45 CFR 248.60, and 45 CFR 249.10(c)(1). The character rather than the licensure status of the institution is of paramount importance.

The excluded institutions are those "primarily" providing care for patients with "mental diseases." An institution is characterized as "primarily" one for mental diseases if it is licensed as such, if it advertises as such or if more than 50 percent of the patients are in fact patients with mental disease. In some instances a facility may be "primarily" concerned with such individuals because they concentrate on managing patients with behavior or functional disorders and are used largely as an alternative care facility for mental hospitals, even if less than 50 percent of the patients have actually been diagnosed as having a mental disease. Mental diseases are those listed under the heading of mental disorders in the eighth revision, International Classification of Diseases, Adapted for Use in the United States (ICDA-8 Public Health Service Publication Number 1693), except that mental retardation is not included for this purpose. The underlying cause of the mental disease is irrelevant. Although many individuals suffer from a combination of mental and physical disorders there is usually no problem in discerning which is responsible for the need for institutional care.

The situation in each State will affect the complexity of identifying those SNF's and ICF's maintained primarily for patients with mental diseases. When they are separately licensed or are under the jurisdiction of the mental health authority, it should be relatively easy. However, when such facilities are not easily distinguishable, a major effort may be needed to identify them and to determine whether Medicaid reimbursement is proper and is limited to individuals 65 and over. Those facilities which are frequently or predominantly used for individuals who are either discharged from mental hospitals or would otherwise be admitted to them are almost certainly in this category but others would also be in this category.

In order to determine whether there is a serious potential problem and what additional steps or resources will be

necessary we are requesting that the attached form be completed for each State in your region. We are focusing attention at this time on SNF's and ICF's as we assume, absent evidence to the contrary, that improper claims related to age are not a problem for care in psychiatric hospitals. Other aspects of the requirements related to psychiatric hospitals will receive attention subsequently.

In addition to the form we would like your overall regional assessment of the scope of any problem, the need for in-depth reviews and steps and man-power necessary to carry them out. Please forward your reports to Mrs. Emily Nichols, Chief, Health Services Branch, Division of Policy and Standards, Room 4513, Switzer Building by January 1, 1976.

/s/ M. KEITH WEIKEL
Commissioner

Attachment
Cleared by OFO
Expiration Date: January 1, 1976

4d

DECEMBER 1975

**COMPLIANCE WITH 45 CFR 249.10(c)(1)
AND 45 CFR 248.60**

STATE: _____

1. In your opinion has the State been aware of and taken action to assure compliance with 45 CFR 248.60 and 249.10(c)(1)?

Yes _____ No _____ Don't know _____

2. Has the State taken steps to identify skilled nursing and intermediate care facilities established and maintained primarily for the care and treatment of patients with mental diseases?

Yes _____ No _____ Don't know _____

3. If yes, describe them.

4. Do you consider them adequate?

Yes _____ No _____ Don't know _____

5. Are these mental health facilities subject to special State licensure standards or requirements?

Yes _____ No _____

6. If yes, describe them.

7. Does the State have controls to assure that psychiatric hospital claims are limited to individuals over 65 and under 22?

Yes _____ No _____ Don't know _____

8. If any answer above is either "no" or "don't know" discuss your recommendations for State or Regional action.

9. Describe any measures the Region has taken to monitor compliance with these Regulations.

10. Further comments:

5d

FY-76-97

**DEPARTMENT OF HEALTH,
EDUCATION, AND WELFARE
SOCIAL AND REHABILITATION SERVICE
WASHINGTON, D.C. 20201
May 3, 1976
MEDICAL SERVICES
ADMINISTRATION
INFORMATION - PS
URGENT**

TO: All SRS Regional Commissioners

SUBJECT: *FIELD STAFF INFORMATION AND INSTRUCTION SERIES: FY 76-97 Institutions for Mental Diseases: Possible Compliance Issues*

The varied responses to FSIIS: FY-76-44, November 7, on "Federal Financial Participation in Payments for Care in Institutions for Mental Diseases," have not allayed our concerns regarding payments to institutions for mental diseases but have heightened our awareness of *great discrepancy in the understanding, interpretation and implementation of policy*. FSIIS FY-76-44 had two main purposes:

1) to get overall *Regional* assessments of problems or potential problems concerning States' adherence to 45 CFR 249.10(c)(1), limitation on Federal financial participation in institutions for mental diseases and

2) to solicit your support in the Department's endeavor to assure States' compliance with all Federal requirements governing payment for care in institutions for mental diseases.

The responses were very uneven and a number did not give a *Regional* assessment. Some of the answers which gave us concern indicated: (1) that the questionnaire was xeroxed, sent to States and upon return forwarded to Central Office without *Regional* assessment; (2) that the overall instructions and information in the FSIIS were

misunderstood; (3) that the institutions examined closely were primarily those on the grounds of or connected in some way with mental institutions, not freestanding SNF's or ICFs that "may" be mental institutions; (4) that as the States monitor payments to psychiatric institutions, SNF's and ICFs which may be "institutions for mental disease," are not identified and monitored; (5) that in one State patients in SNF's limited to the mentally ill could be any age and payments would not be restricted to individuals 65 or over; and (6) that some regions are unable to devote time and attention required to provide adequate assessments as the subject of the FSIIS was not a priority item or Regional staff was not sufficient to perform such as task.

The policy regarding FFP in institutions for mental diseases (which may be SNF's and ICFs) is not new! The overall character of a facility has been a point for consideration since the enactment of the "Long Amendment" permitting Federal matching for individuals over 65 in institutions for mental diseases. There has clearly been recognition that some nursing homes and intermediate care facilities were in fact institutions for mental diseases because of the exclusion of these facilities from Federal matching in 1905(a)(4) and (15) of the Social Security Act and their introduction in 1905(a)(14). If institutions for "mental diseases" were only hospitals, these distinctions would not have been necessary.

Free-standing SNF's and ICFs may of themselves be "institutions for mental diseases." The definitions in 45 CFR 248.60 and 249.10(b)(14) lead to these conclusions:

(1) services for individuals 65 years of age or over in institutions for mental diseases specifically include skilled nursing and intermediate care facility services;

(2) "an institution for mental diseases is one primarily engaged in providing diagnosis, treatment or care of persons with mental diseases."

From information received and reviewed over the past months and recent GAO findings, we know that incorrect reimbursements are being made for individuals between 21 and 65 in institutions that are for mental diseases. This situation warrants our attention in terms of State compliance with an eye toward recouping Federal funds at a later date. This was emphasized at the recent meeting with the Associate Regional Commissioners.

Further, it was discussed in some detail by Dr. Willging at the Belmont Conference in March as one of the major priorities of the Medical Services Administration.

It is of utmost importance that Regions begin to assess or continue to assess the situation as it exists now in order to assist States where necessary in complying with applicable Federal Regulations. Our staff is ready to help you with any specific problems or questions and has already been following up on some specific concerns.

/s/ PAUL R. WILLGING
for Commission, MSA

Expiration Date: None

FY-76-156

DEPARTMENT OF HEALTH,
EDUCATION, AND WELFARE
SOCIAL AND REHABILITATION SERVICE
WASHINGTON, D.C. 20201

September 14, 1976

MEDICAL SERVICES
ADMINISTRATION

INFORMATION—PS

TO: SRS Regional Commissioners

SUBJECT: *FIELD STAFF INFORMATION AND IN-
STRUCTION SERIES: FY-76-156 Mental Health Under
Title XIX*

This is to bring you up to date on activities in regard to the mental health aspects of the Medicaid program.

1. We have continued to review and consider the GAO draft report on deinstitutionalization and will be moving to incorporate as many of the recommendations as possible in our current and future work plans. The report emphasizes the need for intradepartmental cooperation and coordination, with which we heartily concur. We recommended such cooperation on a Regional basis to the ARCs and suggested additional discussions with their ADAMHA counterparts. We are attaching a list of that Regional staff.

Although we recognize that both ADAMHA and SRS staff already have heavy priorities and fixed work plans, we nevertheless believe that time spent in discussion or identification of mutual problems or of special competencies or interests can be both helpful and rewarding. We are therefore recommending for your consideration the establishment of a committee similar to one which has been functioning in Washington for several years. It brings together representatives from the various health, Social Security and SRS agencies concerned with mental health programs for discussion of mutual interests and program developments. Recent visits by Central Office staff to

Regional Offices indicate to us the value which might accrue to greater inter-disciplinary and inter-agency exchange and consultation.

2. There continues to be confusion as to whether patients *who no longer need active inpatient hospital psychiatric treatment* and are discharged to a community-based facility, particularly a SNF or ICF, are to be considered patients with mental disease. When such individuals cannot be discharged to independent living or when they are on conditional release status, *they continue to be primarily patients with mental disease*. The spell of mental illness has not been broken and the development of other concurrent or independent physical problems does not affect this. *Patients with mental disease may even develop major physical problems which do not change their primary disability. The function of a mental hospital is to provide active psychiatric treatment of patients with mental problems. A SNF or ICF is not a substitute for a hospital but should be used to provide management/treatment/rehabilitation/a controlled environment and/or other care for patients not needing active psychiatric treatment.* The disease may be in remission, in a period of inactivity or at a chronic stage which requires primarily careful management and observation by professionally supervised mental health staff.

3. We are pleased to note that there has been widespread progress in the efforts to assure observation of the prohibition against Federal matching in institutions for mental disease for individuals under 65 (Reference: FSIIS 76-44 and 76-97). Various methods in addition to those discussed in earlier issuances have been suggested to help States identify suspect facilities, including proximity to State institutions (for example, within a 25-mile radius) and age distribution uncharacteristic of nursing home patients (i.e., a preponderance of individuals under 65). Also, included in these methods would be a determination as to

whether the basis of Medicaid eligibility of patients under 65 in suspect facilities was due to mental disability.

We feel that the steps outlined by Region IV over a six-month period have merit and are summarizing them for the benefit of other Regional Offices: issuance of Regional memoranda to States, answering questions and clarifying policy; discussions with personnel of various agencies within each State; identification through the State Medicaid agencies of suspect facilities; and instructions to the States about steps to be taken to actually determine the character of these facilities—i.e., whether they are institutions for mental diseases. They recommend the use of review teams (constituted in accordance with 45 CFR 250.23(a)(2)(i) or 250.24(a)(2)(i)(A)(C)(D) and (E) whichever is appropriate) to review patients in those facilities where the determination cannot be made without applying the 50 percent criterion. The teams would make a judgment about each patient as to the presence or absence of disability in functioning resulting from a mental disease and whether the mental disability resulted in the patient's need for skilled nursing or intermediate care. Patients would be classified as follows:

- a. Patient with physical problem necessitating nursing home care who has no mental disability;
- b. Patient with mental disability and physical problem, either of which would independently require nursing home care;
- c. Patient with mental disability necessitating nursing home care who has no significant physical problem;
- d. Patient with physical problem that would not independently necessitate nursing home care, but who has a mental disability that would preclude his proper handling of his physical problem outside a nursing home. Therefore, nursing home care is necessitated because of his mental disability in functioning.

Patient categories c and d are designated as mental patients for purposes of this determination, and should be included in the mental patient census. Special attention will be necessary for patients in category b, as discussed in 2 above, and it may not be possible to make the determination solely on the basis of an individual's current condition. Patients with long-standing mental disability develop major physical problems and vice versa. When it is clear that institutional care resulted from one or the other, the patient would be classified according to the original disability. In other instances, no such clear-cut distinction is possible and such patients would not be included in the mental patient census. While patient populations will change, administrative necessity would indicate that the status of a facility would not be changed without special request except at a designated time, such as renewal of provider agreement or at the time of the annual survey.

4. Questions have been raised about access to private patients' records when a count down by patients is necessary to determine whether the majority of patients are there for mental illness. When a private patient record review is not possible, the survey team will have to rely on other factors such as their professional observation, age of patients, discussion with staff of the overall character and nature of the patient's problems, specialties of the attending physicians, and sources of referral. A high percentage of private patients in a facility will tend to make the determination of its character more difficult. However, we believe a properly qualified team can make such a judgment.

5. We are considering further steps, including dissemination of some of this material directly to the State agencies and the formulation of interagency and interdisciplinary workshops. We will be glad to have suggestions and comments or to answer specific questions.

/s/ M. KEITH WEIKEL
Commissioner

Attachment

Expiration Date: None

APPENDIX E

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Care Financing Administration
Baltimore, Maryland 21235

CERTIFIED MAIL—RETURN RECEIPT REQUESTED

Mr. Edward W. Maher
Commissioner
Department of Income Maintenance
110 Bartholomew Avenue
Hartford, Connecticut 06106

RE: File No.
CT-80/01/028

Dear Mr. Maher:

By letter dated May 8, 1980, the Regional Medicaid Director forwarded to your agency the regional office report entitled "Review of Costs Claimed by the Connecticut Department of Income Maintenance for Services Provided to Title XIX Recipients Residing at Middletown Haven Rest Home, Middletown, Connecticut." The report covered the period January 1, 1977, through September 30, 1979. This letter is to convey our determination that payments to this facility totalling \$1,634,655 in Federal financial participation (FFP) are unallowable.

Medicaid regulation 45 CFR 248.60(a)(2) [currently, 42 CFR 435.1008(a)(2)], which implements Section 1905(a)(17)(B) of the Social Security Act, provides that:

"Federal financial participation . . . is not available in medical assistance for any individual who has not attained 65 years of age and who is a patient in an institution for tuberculosis or mental diseases. . . ."

Section 1905(a)(vii)(14) and (16) of the act permits, at the option of the State agency, payment for:

"(14) inpatient hospital services, skilled nursing facility services, and intermediate care facility services for individuals 65 years of age or over in an institution for tuberculosis or mental diseases . . . (16) effective January 1, 1973, inpatient psychiatric hospital services for individuals under age 21, as defined in subsection (h)."

However, Connecticut has elected to exclude services to these mentally ill in institutions for mental diseases (IMDs) as a covered service under its title XIX program.

Regulations at 42 CFR 440.2(b) [formally [sic] 45 CFR 249.10(b)] state:

"Except as limited in part 441, FFP is available in expenditures under the State plan for medical or remedial care and services as defined in this subpart."

Because FFP is not available in payments to IMDs for persons aged 21 to 64, and because the State plan does not cover services by such facilities to individuals under 21 or over 65, no payments to IMDs are eligible for FFP.

The regional office conducted a review of the Middletown Haven Rest Home in order to determine if the facility should be classified as an IMD. Regulations at 42 CFR 435.1009(e)(2) [formally [sic] 45 CFR 249(b)(14)(iv)] state in part:

"'Institution for mental diseases' means an institution that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases whether or not it is licensed as such."

Your May 30, 1980 letter to the Bureaus of Program Operations and Program Policy, Health Care Financing Administration, expressed concern that the regional office report did not focus on the type of care that the facility

provided, and concentrated on the characteristics or diagnoses of the patients. You also stated that the regional office, in making the IMD determination, did not focus on the care actually rendered but "solely on a diagnosis of some of the residents."

Regulations at 42 CFR 435.1009(e)(2) indicate that any criteria used to make an IMD determination should focus on the patient population, not the services the patient receives. Whether a facility is an IMD should be determined by whether or not the overall character of the institution is that of one that provides care to mentally ill individuals.

The Department of Health, Education and Welfare developed criteria to determine what constitutes "primarily engaged" and the "overall character" of a facility under the meaning of the regulations. The criteria, which are consistent with the intent of the regulatory language, are contained in instructions issued by the Medical Services Administration (the predecessor organization to the Medicaid Bureau before reorganization into the Health Care Financing Administration). These are found in the *Field Staff Information and Instruction Series* (FSIIS) #76-44 dated November 7, 1975, 76-97 dated May 3, 1976, and 76-156 dated September 14, 1976.

The following criteria are detailed in the cited FSIIS and were utilized by the regional office in determining whether the Middletown Haven Rest Home met the "overall characteristics" of an IMD:

1. The facility is licensed as an IMD.
2. It is advertised as an IMD.
3. More than 50 percent of the patients have a diagnosis of mental disease as defined in the *International Classification of Diseases*.
4. The facility is used by mental hospitals for alternative care.

5. Mental patients from the community were admitted that may otherwise have entered a mental hospital.
6. The facility is in close proximity to a State mental hospital (a 25-mile radius).
7. The age distribution of a facility is uncharacteristic of nursing home patients (i.e., a preponderance of patients under age 65).
8. The basis of the Medicaid eligibility of patients under age 65 is due to mental disability.

In addition to these eight criteria, the regional office also considered two further factors in reaching their determination. These are:

9. The facility hires staff specialized in the care of the mentally ill.
10. Independent professional reviews conducted by State teams report a preponderance of mental patients in a facility.

The regional office evaluation of these criteria as they apply to the Middletown Haven Rest Home are detailed in pages 6-13 of the regional office report. Based on the results of the regional office review, the Middletown Haven Rest Home has been identified as an IMD.

Because payments for services to the mentally ill in an IMD are not eligible for FFP under the Connecticut State plan, I am disallowing \$1,634,655 FFP. A detailed schedule of total expenditures submitted and FFP disallowed by quarter is as follows:

Quarter Ending	Total Expenditures	FFP
3/31/77	\$ -0-	\$ -0-
6/30/77	91,169	45,584
9/30/77	114,817	57,409
12/31/77	175,041	87,520
3/31/78	163,758	81,879
6/30/78	221,262	110,631
9/30/78	281,382	140,691
12/31/78	690,954	345,477
3/31/79	529,244	264,622
6/30/79	572,792	263,896
9/30/79	473,891	236,946
TOTAL DISALLOWANCE	\$3,269,310	\$1,634,655

This letter constitutes your notice of disallowance in the amount of \$1,634,655 FFP. Please make a decreasing adjustment in that amount on line 10B of your next quarterly expenditure report (Form HCFA-64).

Under Section 1116(d) of the Social Security Act, you have the right to request reconsideration of this disallowance. If reconsideration is requested, your application must be submitted to the Executive Secretary, Departmental Grant Appeals Board, U.S. Department of Health and Human Services, Room 2004, Mary E. Switzer Building, 330 C Street, SW., Washington, D.C. 20201, no later than 30 days after the postmark date of this letter. Your application must clearly identify the question or questions in dispute and contain a full statement of your position with respect to such question or questions and the pertinent facts and reasons in support of such position. You must attach a copy of this letter to your application. Send a copy of your application to me and to the Regional Medicaid Director. Your application will be processed pursuant to the rules and regulations of the Departmental Grant Appeals Board which are currently found at 45 CFR part 16, as amended. See *Federal Register*, Vol. 43, No. 44, published March 6, 1978.

6e

Should you require further details regarding this matter, please contact the Regional Medicaid Director at (617) 223-6881.

Sincerely,

/s/ PAUL WILLGING

Mildred L. Tyssowski

Director

Bureau of Program Operations

cc: Regional Medicaid Director, Region I
Regional Administrator, Region I

(9)
No. 83-2136

Office - Supreme Court, U.S.

FILED

FEB 19 1985

ALEXANDER L. STEVAS

In the Supreme Court of the United States

OCTOBER TERM, 1984

STATE OF CONNECTICUT, DEPARTMENT OF
INCOME MAINTENANCE, PETITIONER

v.

MARGARET M. HECKLER, SECRETARY OF HEALTH AND
HUMAN SERVICES, AND THE UNITED STATES DEPARTMENT
OF HEALTH AND HUMAN SERVICES

ON WRIT OF CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR THE RESPONDENTS

REX E. LEE

Solicitor General

RICHARD K. WILLARD

Acting Assistant Attorney General

KENNETH S. GELLER

Deputy Solicitor General

KATHRYN A. OBERLY

Assistant to the Solicitor General

ROBERT S. GREENSPAN

HOWARD S. SCHER

Attorneys

Department of Justice

Washington, D.C. 20530

(202) 633-2217

634

QUESTION PRESENTED

Whether "intermediate care facilities" (ICFs) that are primarily engaged in the diagnosis, treatment, or care of the mentally ill also may be classified as "institutions for mental diseases" (IMDs) under the Medicaid statute, thereby rendering such ICFs subject to the statutory ban against Medicaid coverage for services rendered to persons over age 21 and under age 65 in an IMD.

TABLE OF CONTENTS

	Page
Opinions below	1
Jurisdiction	1
Statute involved	2
Statement	2
A. The statutory and regulatory scheme	2
B. The facts of this proceeding	9
Introduction and summary of argument	14
Argument:	
I. The term "institution for mental diseases" is not limited to large, traditional mental hospitals	19
A. The Secretary's interpretation of the term "IMD" is supported by the plain language of the statute	21
B. The legislative history fully supports the Secretary's interpretation of the IMD exclusion	29
C. The Secretary's interpretation of the IMD exclusion is entitled to deference	35
D. The facts of this case demonstrate why Congress could not have intended to limit IMDs to traditional mental hospitals	43
II. The disallowance at issue does not contravene the concepts of "federalism" that underlie the Medicaid program	43
A. Connecticut's "federalism" argument is not properly before the Court	43
B. Connecticut's "federalism" argument is erroneous in light of the statute and the record in this case	49
Conclusion	51
Appendix A	1a
Appendix B	3a

IV

TABLE OF AUTHORITIES

Cases:	Page
<i>Aluminum Co. of America v. Central Lincoln Peoples' Utility Dist.</i> , No. 82-1071 (June 5, 1984)....	42
<i>Bankamerica Corp. v. United States</i> , No. 81-1487 (June 8, 1983)	29
<i>Bell v. New Jersey</i> , 461 U.S. 773	19, 50
<i>Board of Governors of Federal Reserve System v. Investment Co. Institute</i> , 450 U.S. 46	20
<i>Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.</i> , No. 82-1005 (June 25, 1984)	20
<i>Consumer Product Safety Commission v. GTE Sylvania, Inc.</i> , 447 U.S. 102	21
<i>Fedorenko v. United States</i> , 449 U.S. 490	23
<i>Harris v. McRae</i> , 448 U.S. 297	2
<i>Illinois v. United States Dep't of Health and Human Services</i> , No. 82-C-1349 (N.D. Ill. Mar. 20, 1984), appeal pending, No. 84-2615 (7th Cir.)....	47
<i>Irvine v. California</i> , 347 U.S. 128	48
<i>Kantrowitz v. Weinberger</i> , 388 F. Supp. 1127, aff'd, 530 F.2d 1034, cert. denied, 429 U.S. 819..	20
<i>Lawrence County v. Lead-Deadwood School Dist.</i> No. 40-1, No. 83-240 (Jan. 9, 1985)	23
<i>Legion v. Richardson</i> , 354 F. Supp. 456, aff'd sub nom. <i>Legion v. Weinberger</i> , 414 U.S. 1058.....	20
<i>Massachusetts v. Sec'y of Health & Human Services</i> , 749 F.2d 89	51
<i>Minnesota v. Heckler</i> , 718 F.2d 852	45-46, 47
<i>Minnesota v. Schweiker</i> , No. 4-82-155 (D. Minn. Aug. 25, 1982)	46
<i>O'Bannon v. Town Court Nursing Center</i> , 447 U.S. 773	39
<i>Pennhurst State School & Hospital v. Halderman</i> , 451 U.S. 1	48, 50
<i>Pennhurst State School & Hospital v. Halderman</i> , No. 81-2101 (Jan. 23, 1984)	35
<i>Reiter v. Sonotone Corp.</i> , 442 U.S. 330	22
<i>Schweiker v. Gray Panthers</i> , 453 U.S. 34	2, 20, 38
<i>Schweiker v. Wilson</i> , 450 U.S. 221	17, 20, 38, 39, 45
<i>Sec'y of Education v. Kentucky</i> , No. 83-1798 (argued Jan. 8, 1985)	50, 51

V

Cases—Continued:

Page

<i>Tidelands Marine Service v. Patterson</i> , 719 F.2d 126	43
<i>United States v. New Mexico</i> , 455 U.S. 720.....	34

Statutes and regulations:

<i>Community Mental Health Centers Act</i> , Pub. L. No. 88-164, Tit. II, 77 Stat. 290 <i>et seq.</i>	4, 40
42 U.S.C. 2681 <i>et seq.</i> (repealed) codification note	40
<i>Medicare and Medicaid Budget Reconciliation Amendments of 1984</i> , Pub. L. No. 98-369, § 2335 (f), 98 Stat. 1091	36-37
<i>Mental Health Systems Act</i> , Pub. L. No. 96-398, 94 Stat. 1564 <i>et seq.</i>	40
<i>Omnibus Budget Reconciliation Act of 1981</i> , Pub. L. No. 97-35, § 902, 95 Stat. 560, codified at 42 U.S.C. 300x <i>et seq.</i> , as amended by Pub. L. No. 98-509, 98 Stat. 2353	40
42 U.S.C. 300x-3 (b) (1)	40
42 U.S.C. 300x-4 (c) (5)	16
42 U.S.C. 300x-4 (e)	40
<i>Rehabilitation Act of 1973</i> , 29 U.S.C. 794	39
<i>Social Security Act</i> , Tit. XI, 42 U.S.C. 1301 <i>et seq.</i> :	
42 U.S.C. 1302	20
42 U.S.C. 1395x (j)	39
<i>Social Security Act</i> , Tit. XIX, 42 U.S.C. 1396 <i>et seq.</i> , as amended by the Medicare and Medicaid Budget Reconciliation Amendments of 1984, Pub. L. No. 98-369, 98 Stat. 1061 <i>et seq.</i>	2, 1a
42 U.S.C. 1396a	2, 3
42 U.S.C. 1396a (a) (10)	25, 38
42 U.S.C. 1396a (a) (20)	15, 24, 25
42 U.S.C. 1396a (a) (20) (A)	27
42 U.S.C. 1396a (a) (21)	15, 23, 24, 25
42 U.S.C. 1396a (a) (26) (A)	10
42 U.S.C. 1396a (a) (31) (A)	10
42 U.S.C. 1396b (d) (1)	19, 50
42 U.S.C. 1396b (d) (5)	19, 50

VI

Statutes and regulations—Continued

Page

42 U.S.C. 1396d	24, 25
42 U.S.C. 1396d (a)	3, 20, 21, 1a
42 U.S.C. 1396d (a) (1)	3, 4, 21, 22, 1a
42 U.S.C. 1396d (a) (4) (A)	3, 18, 21, 22, 1a
42 U.S.C. 1396d (a) (14)	22, 24, 25, 29, 31, 1a
42 U.S.C. 1396d (a) (15)	3, 5, 18, 21, 22, 1a
42 U.S.C. 1396d (a) (16)	23, 25, 1a
42 U.S.C. 1396d (c)	25, 26, 39, 2a
42 U.S.C. 1396d (c) (1)	25
42 U.S.C. 1396d (d)	5, 14, 26
42 U.S.C. 1396d (h)	16, 18, 23
42 U.S.C. 1396d (a) (B)	3, 4, 22, 25
Social Security Act Amendments of 1950, ch. 809, § 351, 64 Stat. 558	3
Social Security Amendments of 1960, Pub. L. No. 86-778, § 601(f) (1)-(2), 74 Stat. 991	3
Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 <i>et seq.</i>	4
Section 121 (a), 79 Stat. 343:	
§ 1902 (a) (20), 79 Stat. 347	4
§ 1902 (a) (21), 79 Stat. 347	4
§ 1905 (a) (1), 79 Stat. 351	4
§ 1905 (a) (4), 79 Stat. 351	4
§ 1905 (a) (14), 79 Stat. 352	4
§ 1905 (a) (B), 79 Stat. 352	4
Social Security Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1329 <i>et seq.</i> :	
§ 297, 86 Stat. 1459-1460	22, 31
§ 299B(a) and (b), 86 Stat. 1460-1461	6
Pub. L. No. 89-105, 79 Stat. 427	40
Pub. L. No. 90-248, § 250, 81 Stat. 920-921	5
Pub. L. No. 92-223, § 4(a) (2), 85 Stat. 809 (42 U.S.C. 1396(d))	5
42 C.F.R. 435.1009 (e)	8, 10, 24, 25, 43
42 C.F.R. Pt. 456	10
45 C.F.R. Pt. 16	13
45 C.F.R. 248.60 (a) (3) (ii) (1972)	7
45 C.F.R. 248.60 (b) (7) (1972)	7

VII

Statutes and regulations—Continued

Page

45 C.F.R. 1970:

Section 249.10 (b) (1)	7
Section 249.10 (b) (4) (i)	7
Section 249.10 (b) (14) (iv)	7
45 C.F.R. 249.10 (b) (14) (iv) (1973)	7, 43
45 C.F.R. 249.10 (b) (14) (iv) (1974)	7, 43

Miscellaneous:

Ahmed, <i>Whither the State Hospital? Issues and Trends in Mental Services Delivery, in State Mental Hospitals</i> (P. Ahmed & S. Plog ed. 1977)	36
110 Cong. Rec. 21349 (1964)	15
117 Cong. Rec. (1971):	
p. 44720	6
p. 44721	34
34 Fed. Reg. (1969):	
p. 9785	7
p. 9787	7
36 Fed. Reg. 3872 (1971)	7
39 Fed. Reg. 2221 (1974)	7
42 Fed. Reg. 52826 (1977)	8
43 Fed. Reg. 45176 (1978)	8
Goldman, Adams & Taube, <i>Deinstitutionalization: The Data Demythologized, Hospital & Commu- nity Psychiatry</i> 129 (Feb. 1983)	37
H. Gottesfeld, <i>Alternatives to Psychiatric Hos- pitalization</i> (1977)	36
H.R. Rep. 694, 88th Cong., 1st Sess. (1963)	40
H.R. Rep. 213, 89th Cong., 1st Sess. (1965)	4
H.R. Rep. 92-1605, 92d Cong., 2d Sess. (1972)	31
H.R. Rep. 98-861, 98th Cong., 2d Sess. (1984)	37
M. Levine, <i>From State Hospital to Psychiatric Center</i> (1980)	38
S. Rep. 180, 88th Cong., 1st Sess. (1963)	40
S. Rep. 366, 89th Cong., 2d Sess. (1965)	40
S. Rep. 404, 89th Cong., 1st Sess. (1965)	4, 28, 29, 32
S. Rep. 96-712, 96th Cong., 2d Sess. (1980)	40

VIII

Miscellaneous—Continued:

Page

S. Rep. 97-139, 97th Cong., 1st Sess. (1981)	41
S. Rep. 98-381, 98th Cong., 2d Sess. (1984)	41
<i>Social Security Amendments of 1967: Hearings on H.R. 12080 Before the Senate Comm. on Finance, 90th Cong., 1st Sess. (1967)</i>	30
<i>Social Security Amendments of 1970: Hearings on H.R. 17550 Before the Senate Comm. on Finance, 91st Cong., 2d Sess. (1970)</i>	5, 15, 16, 30, 31, 33, 35, 36
<i>Social Security Amendments of 1971: Hearings on H.R. 1 Before the Senate Comm. on Finance, 92d Cong., 1st & 2d Sess. (1972)</i>	30, 33
<i>Stotsky & Stotsky, Nursing Homes: Improving a Flawed Community Facility, Hospital & Community Psychiatry 238 (Mar. 1983)</i>	38
<i>U.S. Comptroller General, Rep. No. HRD-76-152, Returning the Mentally Disabled to the Community: Government Needs to Do More (1977)</i>	37
<i>U.S. Dep't of Health, Education, and Welfare, Handbook of Public Assistance Administration, Supplement D—Medical Assistance Programs Under Title XIX of the Social Security Act (1966)</i>	6

In the Supreme Court of the United States

OCTOBER TERM, 1984

No. 83-2136

STATE OF CONNECTICUT, DEPARTMENT OF
INCOME MAINTENANCE, PETITIONER

v.

MARGARET M. HECKLER, SECRETARY OF HEALTH AND
HUMAN SERVICES, AND THE UNITED STATES DEPARTMENT
OF HEALTH AND HUMAN SERVICES

ON WRIT OF CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR THE RESPONDENTS

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-16a) is reported at 731 F.2d 1052. The opinion of the district court (Pet. App. 1c-25c) is reported at 557 F. Supp. 1077. The opinion of the Departmental Grant Appeals Board of the United States Department of Health and Human Services (Pet. App. 1d-61d) is not reported.

JURISDICTION

The judgment of the court of appeals (Pet. App. 1b-2b) was entered on March 30, 1984. The petition for a writ of certiorari was filed on June 28, 1984, and was granted on October 29, 1984. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

(1)

STATUTE INVOLVED

Relevant provisions of the Medicaid statute, Title XIX of the Social Security Act, as amended, 42 U.S.C. 1396 *et seq.*, as further amended by the Medicare and Medicaid Budget Reconciliation Amendments of 1984, Pub. L. No. 98-369, 98 Stat. 1061 *et seq.*, are reproduced as Appendix A to this brief.

STATEMENT

Petitioner brought this action to challenge the disallowance of federal Medicaid reimbursement for services provided to patients at Middletown Haven Rest Home, a state-licensed "intermediate care facility" (ICF). The Secretary of Health and Human Services concluded that the disallowance was mandated after an audit revealed that the "overall character" of Middletown Haven is that of an "institution for mental diseases" (IMD), for which Medicaid reimbursement is barred by statute. While not disputing the fact that Middletown Haven specializes in the care and treatment of the mentally ill, petitioner contends that IMDs encompass only traditional mental hospitals and argues that an ICF can never be an IMD, regardless of its "overall character" as a facility established and maintained primarily for the care and treatment of the mentally ill.

A. The Statutory And Regulatory Scheme

1. The Medicaid program was established pursuant to Title XIX of the Social Security Act, 42 U.S.C. 1396 *et seq.*, "for the purpose of providing federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons." *Harris v. McRae*, 448 U.S. 297, 301 (1980). To participate in the program, a state must develop a Medicaid plan that is consistent with the requirements of Title XIX and federal regulations promulgated thereunder. 42 U.S.C. 1396a. See *Schweiker v. Gray Panthers*, 453 U.S. 34, 37 (1981). Following approval of the plan by the Secretary of Health

and Human Services, the state is entitled to federal financial assistance in the provision of medical care to eligible individuals who are covered by the state plan. 42 U.S.C. 1396a.

The Medicaid statute specifically excludes from coverage services provided to any person more than 21 and under 65 years of age who is a patient in an "institution for mental diseases" (IMD). 42 U.S.C. 1396d(a). The statute defines "medical assistance" for which federal financial participation is available to include inpatient hospital services, skilled nursing facility (SNF) services, and intermediate care facility (ICF) services, other than such services provided in an institution for mental diseases. 42 U.S.C. 1396d(a)(1), (4)(A), and (15). Payments for services to individuals under age 65 who are patients in an IMD (other than inpatient psychiatric care for persons under age 21) are further specifically prohibited by 42 U.S.C. 1396d(a)(B).

2. The history of the so-called IMD exclusion dates back to 1950. In that year, Congress adopted a system of federal grants to the states for the operation of state programs to aid the permanently and totally disabled. The statute establishing the grant program specifically excluded payments on behalf of "any individual * * * who is a patient in an institution for * * * mental diseases." Social Security Act Amendments of 1950, ch. 809, § 351, 64 Stat. 558. When "medical assistance" for the aged was added to the grant program in 1960, that term was similarly defined to exclude payments for "care in behalf of * * * any individual who is a patient in an institution for * * * mental diseases." Social Security Amendments of 1960, Pub. L. No. 86-778, § 601(f)(1) and (2), 74 Stat. 991.¹

¹ Congress did authorize coverage for up to six weeks of care in a medical institution for eligible individuals of any age diagnosed as having a psychosis. Social Security Amendments of 1960, Pub. L. No. 86-778, § 601(f)(1) and (2), 74 Stat. 991.

When Congress enacted the Medicaid program in 1965, Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 *et seq.*, it retained the general bar against payments for services rendered in IMDs. Section 121(a), § 1905(a)(1), (4), and (B), 79 Stat. 351-352.² This exclusion was based on Congress's understanding that the long-term care of patients in mental institutions "had traditionally been accepted as a responsibility of the States." S. Rep. 404, 89th Cong., 1st Sess. 144 (1965); see *id.* at 146; H.R. Rep. 213, 89th Cong., 1st Sess. 126, 128 (1965). For the first time, however, Congress provided Medicaid coverage for needy individuals over age 64 in institutions for mental diseases (Section 121(a), § 1905(a)(14), 79 Stat. 352). As a condition of extending coverage to those over age 64 in IMDs, Congress required participating states to develop plans for the use of other forms of care for the aged mentally ill and to conduct initial and periodic reviews of each elderly patient to ensure appropriate treatment for each individual. Section 121(a), § 1902(a)(20), 79 Stat. 347; S. Rep. 404, *supra*, at 145. As yet a further condition on the extension of IMD coverage to the elderly, Congress required participating states to demonstrate satisfactory progress toward developing and implementing comprehensive mental health programs. Section 121(a), § 1902(a)(21), 79 Stat. 347. This requirement was intended to ensure that "States move ahead promptly to develop comprehensive mental health plans as contemplated in the Community Mental Health Centers Act of 1963 [Pub. L. No. 88-164, Tit. II, 77 Stat. 290 *et seq.*]." S. Rep. 404, *supra*, at 146.³

² Congress did authorize Medicaid coverage for the eligible mentally ill in general hospitals and general SNFs. Section 121(a), § 1905(a)(1) and (4), 79 Stat. 351. See S. Rep. 404, 89th Cong., 1st Sess. 144, 216-217 (1965).

³ The Community Mental Health Centers Act, and its relevance to the question presented in this case, is discussed in detail at pages 16, 39-41 & note 31, *infra*.

In 1971, Congress amended the definition of "medical assistance" under the Medicaid program to include ICF services.⁴ Pub. L. No. 92-223, § 4(a)(2), 85 Stat. 809. As with inpatient hospital services and skilled nursing facility services, which had been considered "medical assistance" under the Medicaid program since its enactment in 1965, the 1971 ICF provision contained a specific exclusion for ICF services in IMDs, an exclusion that remains in the statute today (42 U.S.C. 1396d(a)(15)).⁵

⁴ ICF services had been covered under the programs of cash assistance for the aged, blind, and disabled since 1967. Pub. L. No. 90-248, § 250, 81 Stat. 920-921. As previously noted (see page 3, *supra*), these cash assistance programs excluded payments made for the care of individuals in IMDs. Nothing in the 1967 legislation adding ICF coverage to the cash assistance programs altered the blanket IMD exclusion for persons under age 65.

⁵ In the same Act (Pub. L. No. 92-223, § 4(a)(2), 85 Stat. 809, codified at 42 U.S.C. 1396d(d)), Congress provided that ICF services for which federal financial assistance is available could include "services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions." Congress specified that the primary purpose of such an institution (or distinct part thereof) had to be the provision of health or rehabilitative services for mentally retarded individuals, that mentally retarded individuals for whom federal assistance was requested had to be receiving active treatment, and that states could not use federal money to reduce their own expenditures with respect to the mentally retarded. *Ibid.*

Congress was aware that the medical profession viewed mental retardation differently from mental illness; it was told that the mentally retarded are persons suffering from "subaverage general intellectual functioning which originates during the developmental period and is associated with impaired adaptive behavior." *Social Security Amendments of 1970: Hearings on H.R. 17550 Before the Senate Comm. on Finance*, 91st Cong., 2d Sess. 506 (1970) (statement of Dr. Kenneth Gaver, Administrator, Oregon Division of Mental Health) (citation omitted). Dr. Gaver went on to state that (*ibid.*):

[Institutions for the mentally retarded] use different methods than do mental hospitals. * * * They focus on different goals. Their concern is to train the mentally retarded person

In 1972, Congress further broadened the class of mentally ill patients eligible for Medicaid coverage by extending benefits to children. Social Security Amendments of 1972, Pub. L. No. 92-603, § 299B(a) and (b), 86 Stat. 1460-1461. The 1972 amendments extended Medicaid coverage to persons under age 21 who are inpatients in psychiatric hospitals, provided, inter alia, that the treatment they are receiving is certified as being likely to improve their condition.

3. Congress has never defined the term "institution for mental diseases." The Secretary, however, has defined IMDs by regulation. Shortly after enactment of the Medicaid program in 1965, the Secretary provided that federal reimbursement could not be claimed for:

Any individual who has not attained 65 years of age and is a patient in an institution * * * for mental diseases; i.e., an institution whose overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases (whether or not it is licensed).

U.S. Dep't of Health, Education, and Welfare, *Handbook of Public Assistance Administration, Supplement D—Medical Assistance Programs Under Title XIX of the Social Security Act* ¶ D-4620.2 (1966) [hereinafter cited as *HPA*].⁶ The *HPA* was later replaced with formal

to his maximum level of personal independence and to place him in a community setting if possible.

See also 117 Cong. Rec. 44720 (1971) (remarks of Sen. Bellmon) ("[T]here are public institutions whose primary objective is the active provision of rehabilitative, educational and training services to enhance the capacity of mentally retarded individuals to care for themselves or to engage in employment. [Such] institutions * * * should be subject to Federal participation under adequate safeguards.").

⁶ The 1966 *HPA* also defined an IMD as an institution that met "the requirements for a psychiatric hospital under title XVIII, section 1861(f), of the Social Security Act," or, for a three-year period only, was approved by appropriate state agencies as "a hospital established for the care of the mentally ill." *HPA* ¶ D-

regulations. Regulations promulgated in 1969 essentially restated the *HPA* definition of an IMD in negative fashion; that is, the regulations provided that covered "[i]npatient hospital services" are those items and services ordinarily furnished by the hospital for the care and treatment of inpatients * * * *in an institution maintained primarily for treatment and care of patients with disorders other than * * * mental diseases.*" 34 Fed. Reg. 9785 (1969), codified at 45 C.F.R. 249.10(b)(1) (1970) (emphasis added). Similarly, skilled nursing home services were defined as "those items and services furnished by a skilled nursing home *maintained primarily for the care and treatment of inpatients with disorders other than * * * mental diseases.*" 34 Fed. Reg. 9785 (1969), codified at 45 C.F.R. 249.10(b)(4)(1) (1970) (emphasis added).⁷

In 1971, the Secretary promulgated regulations dealing generally with "institutional status." With respect to IMDs in particular, the 1971 regulations provided (36 Fed. Reg. 3872 (1971), codified at 45 C.F.R. 248.60(a)(3)(ii) and (b)(7) (1972)):

Whether an institution is one for * * * mental diseases will be determined by whether its overall

5141.14.d. At the time this definition was adopted, however, ICFs were not encompassed within the Medicaid program, and there is little, if any, evidence to show that significant numbers of SNFs were primarily engaged in the care and treatment of mental patients. See Br. for the American Psychiatric Ass'n et al. at 8.

⁷ Like the *HPA*, the 1969 regulations also defined an IMD as an institution meeting the requirements of the Social Security Act for a psychiatric hospital or, for a temporary period only, an institution certified by an appropriate state agency as a hospital established for the care of the mentally ill. 34 Fed. Reg. 9787 (1969), codified at 45 C.F.R. 249.10(b)(14)(iv) (1970). See note 6, *supra*. This definition was eliminated in 1974, when the agency promulgated regulations to implement the statutory transfer of ICF coverage from the old cash assistance programs to the Medicaid program. See 39 Fed. Reg. 2221 (1974), and compare 45 C.F.R. 249.10(b)(14)(iv) (1973) with 45 C.F.R. 249.10(b)(14)(iv) (1974).

character is that of a facility established and maintained primarily for the care and treatment of individuals with * * * mental diseases (whether or not it is licensed);

* * * * *

"Institution for mental diseases" means an institution which is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services.^[8]

The current definition of an IMD substantially tracks the original definition contained in the 1966 HPA and carried forward in subsequent regulations. An IMD is defined as (42 C.F.R. 435.1009(e)):

an institution^[9] that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.

The Secretary has supplemented this definition with a series of field staff instructions that describe the relevant criteria to be considered in determining whether or not the "overall character" of a facility is that of an IMD. These criteria instruct audit teams to focus on the following characteristics of an institution under review (Pet. App. 5a n.2):

⁸ In 1977 and 1978, the applicable regulations were redesignated and recodified without substantive change as part of Title 42 of the Code of Federal Regulations. See 42 Fed. Reg. 52826 (1977); 43 Fed. Reg. 45176 (1978).

⁹ An "institution" is defined as any establishment that furnishes food, shelter, and some treatment or services to four or more persons unrelated to the proprietor. 42 C.F.R. 435.1009(e).

1. Licensed as a mental institution.
2. Advertised as a mental institution.
3. More than 50% of the patients have a disability in mental functioning.
4. Used by mental hospitals for alternative care.
5. Patients who may have entered mental hospitals are accepted directly from the community.
6. Proximity to State mental institutions (within a 25 mile radius).
7. Age distribution uncharacteristic of nursing home patients.
8. Basis of Medicaid eligibility for patients under 65 is due to mental disability.
9. Hires staff specialized in the care of the mentally ill.
10. Independent professional reviews conducted by state teams report a preponderance of mental illness among patients in the facility.

B. The Facts Of This Proceeding

The State of Connecticut brought this action in the United States District Court for the District of Connecticut, seeking review of a decision by the Department of Health and Human Services (HHS) disallowing federal financial assistance claimed by Connecticut under the Medicaid program for services provided to patients at Middletown Haven Rest Home, a private long-term care facility. The facility was certified by the State as an ICF during the fiscal quarters at issue here, from January 1977 through September 1979. The State received \$1,634,655 in federal financial assistance for payments it made to Middletown Haven during those quarters.

1. Federal payments to the State on behalf of Middletown Haven came under scrutiny in December 1979, when an audit team from HHS undertook a detailed review

of the facility (Pet. App. 4a-5a). The review was part of a much larger study conducted to determine whether certain states, including Connecticut, "were discharging patients from mental hospitals and arranging their placement in ICF's in order to circumvent the Medicaid exclusion for patients under 65 in IMD's" (*id.* at 5a). Both HHS and the General Accounting Office had learned that a number of states were replacing large mental hospitals with smaller institutions, such as SNFs and ICFs, thereby changing the character of these smaller facilities into IMDs. J.A. 1d, 6d-7d.

Applying the criteria developed by HHS to supplement the regulatory definition of an IMD (see page 9, *supra*), an audit team consisting of a psychiatrist, psychiatric nurse, auditor, financial management consultant, and Medicaid program specialist conducted an extensive review of Middletown Haven to determine whether it was an IMD (J.A. 3a). The team examined the facility's license and staffing procedures (J.A. 9a); reviewed Independent Professional Review (IPR) reports and Medical Review (MR) reports prepared by the State (J.A. 9a-10a);¹⁰ and held discussions with the facility's owner, administrator, and staff, and with state medical and financial personnel (J.A. 10a).

In addition, the psychiatrist and psychiatric nurse conducted a detailed review of the facility's patient records in order to determine patient diagnoses (J.A. 9a). From three sources—Middletown Haven's patient log, a patient census report prepared by Middletown Haven for the Connecticut Department of Health, and Medicaid claims paid—the audit team assembled a list of patients treated in the facility since it had opened in January 1977 (J.A. 15a-16a). The psychiatrist devised a protocol for reviewing the medical records of these patients. In

¹⁰ IPR and MR reports are reviews conducted by state personnel of every Medicaid patient in facilities certified by a state as Medicaid eligible. The reviews are required by statute (42 U.S.C. 1396a(a)(26)(A) and (31)(A)) and regulation (42 C.F.R. Pt. 456).

74 sample cases on which the protocol was tested, all three reviewers (the psychiatrist, the psychiatric nurse, and the Medicaid program specialist) arrived independently at the same diagnosis (J.A. 16a). Concluding that the sample cases validated the review methodology, the same method was then used to evaluate the remaining 395 patients (*ibid.*). If there was "even the slightest possibility of a question" in a particular case, the case was referred to the psychiatrist for final determination (*ibid.*). In such cases, the psychiatrist often consulted with the facility's staff (C.A. App. 64-65).

Patient diagnoses were classified according to the "International Classification of Diseases, Adapted for Use in the United States,' Eighth Revision, Public Health Service Publication No. 1693" (Pet. App. 21d & n.19, 42d n.29). The diagnoses most frequently reported by the State itself, and with which the audit team agreed, were schizophrenia, paranoia, psychotic depressive reaction, depression psychosis, acute dissociative reaction, manic depressive psychosis, catatonic schizophrenia, and alcoholism with acute brain syndrome (J.A. 23a).

The audit team determined, based on the criteria developed to identify IMDs (see page 9, *supra*), that Middletown Haven met the definition of an IMD set forth at 42 C.F.R. 435.1009(e). The team noted that some of the factors carried greater weight than others (J.A. 13a), and it explained the importance attached to each factor (J.A. 13a-24a). The audit team's major findings were as follows (J.A. 13a-24a; Pet. App. 40d-44d):

1. Seventy-seven percent of the patients in the facility during the period January 1977 to December 1979 had a major mental illness that was a substantial part of their need for ongoing care. Even if those patients with primary diagnoses of alcoholism or organic brain syndrome were excluded, the majority of patients were placed in the facility because of mental illness.
2. More than 50% of the patients had been admitted directly from state mental hospitals.

3. The facility is located only three miles from a state mental hospital and was used by that hospital and two other mental hospitals as an alternative placement site. Of 209 patients at Middletown Haven during fiscal year 1978, 167 came directly from state mental hospitals. An additional 42 came from other institutions (hospitals, SNFs, ICFs, residential facilities). Only four patients came directly from their homes. Whatever their previous placement, all patients had diagnoses similar to those of the patients admitted from the state mental hospital.

4. The age distribution in the facility was uncharacteristic of general nursing home populations. The average nursing home patient in the United States is approximately 82, and 63% are over age 65. At Middletown Haven, the distribution pattern was reversed; 64% of the population was between the ages of 22 and 64.

5. The facility's license from the State contained a "psychiatric rider" authorizing it to "care for persons with certain psychiatric conditions."

6. The facility advertised itself to the community and to potential sources of referral as a facility specializing in mental diseases.

7. The facility hired medical and other staff with specialized training and experience in the care of the mentally ill. The facility employed three physicians to provide services to its patients, and all three were psychiatrists. Even the non-medical staff were informed at the time they were hired of the emphasis on psychiatric conditions and were selected on the basis of their ability to deal with that situation. All employees participated in in-service training for the care of the mentally ill. Staff members indicated that they believed Middletown Haven was a psychiatric facility.

8. The facility's admissions policy stated that all patients "must be certified to be ambulatory and able to care for themselves," indicating that the patients

were not institutionalized primarily for physical illnesses.

9. A sample of reports of the medical reviews performed by the State indicated that 65% of the patients were found to have a primary or single diagnosis of psychiatric condition as the basis for their disability eligibility under Medicaid.

10. State employees conducted four independent professional reviews during the period in question, examining each patient's diagnosis, medication, and history. These reviews documented an increasing percentage of patients with mental diagnoses, ranging from 55% to 67% of the Medicaid patient population. The amount of psychotropic drugs used also indicated a high percentage of psychiatric patients in the facility.

Based on these facts, more fully set forth in its report, the audit team concluded that Middletown Haven was primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases and was, therefore, an "institution for mental diseases" for purposes of the Medicaid statute. HHS then notified the State that it was disallowing the federal financial assistance previously paid to the State for services rendered at Middletown Haven (J.A. 1e).

2. Connecticut appealed the disallowance to the HHS Departmental Grant Appeals Board pursuant to 45 C.F.R. Pt. 16. Connecticut's appeal was consolidated with the appeals of three other states (Minnesota, Illinois, and California) seeking review of findings that certain facilities in those states were IMDs. The Board upheld all of the disallowances, finding substantial evidence in the record that the "overall character" of each of the facilities was such that it met the regulatory definition of an IMD (Pet. App. 1d-61d). The Board's decision constituted the final agency decision.

3. Connecticut sought judicial review of the Secretary's decision in the district court. The district court granted Connecticut's motion for summary judgment (Pet. App.

1c-25c), holding that the IMD exclusion in the Medicaid statute "excludes only care in mental hospitals, meaning care in facilities which, at the least, provide total care to mental patients" (*id.* at 25c).¹¹

The court of appeals reversed (Pet. App. 1a-16a). Relying on the language and legislative history of the IMD exclusion, the court rejected Connecticut's contention that "the IMD exclusion was intended to foreclose federal financial assistance only for services provided in traditional state mental hospitals" (*id.* at 7a). The court noted that the provisions of 42 U.S.C. 1396d "are meaningless unless some ICF's are IMD's and thus subject to the statutory exclusion" (Pet. App. 10a). Accordingly, the court concluded that Congress intended the IMD exclusion "to block the use of Medicaid funds to help pay for the care of the mentally ill under 65 in a broad range of institutions subsumed under the label 'institutions for mental diseases,' including ICF's" (*id.* at 15a), and that "the IMD definition adopted by HHS and supplemented by its internal criteria reasonably implements Congress' intent" (*ibid.*).

INTRODUCTION AND SUMMARY OF ARGUMENT

I. Before delving into the Byzantine structure of the Social Security Act, it is appropriate to place Connecticut's rather sweeping generalizations about congressional intent in some perspective. Connecticut does not deny that Middletown Haven specializes in the care and treatment of the mentally ill. Nevertheless, Connecticut argues that the IMD exclusion is limited to traditional mental hospitals and that an ICF can never be an IMD, no matter what its "overall character." Connecticut relies (Br. 16-

¹¹ The district court's "total care" concept appears nowhere in the statute, regulations, or legislative history. Moreover, "total care," as defined by the district court, appears to have little or nothing to do with any particular level of *psychiatric* care (see Pet. App. 14c). Instead, the district court defined "total care" as "the very high level of care given, for example, to a hospital inpatient or a nursing home resident. The patient is totally dependent on the institution and is submerged in it" (*id.* at 7c n.9).

17) on two assumptions made by Congress in the 1950's about mental hospitals: (1) that the care of patients in such facilities was traditionally a state responsibility and (2) that Congress wanted to encourage the development of "alternatives" to traditional mental hospitals because it viewed those facilities as mere "dumping grounds" for the mentally ill. Both of these assumptions may be accepted as true (although the second is no longer valid), but it does not follow that Congress has ever expressed an intent to extend Medicaid coverage to the mentally ill under age 65 in "alternative" facilities such as ICFs. On the contrary, Congress's cautious approach to increasing federal financial support for the mentally ill requires the opposite conclusion.

Looking first at the cost of caring for the mentally ill, there is ample evidence that Congress always has been reluctant to shift that fiscal responsibility from the states to the federal government. Initially, Congress refused to fund services for any category of the mentally ill. See page 3, *supra*. In its first major step away from that blanket prohibition, Congress provided coverage for the needy aged. It did so in recognition of the fact that health costs for the elderly are a particularly serious problem (S. Rep. 404, *supra*, at 277 (supplemental views); *Social Security Amendments of 1970: Hearings on H.R. 17550 Before the Senate Comm. on Finance*, 91st Cong., 2d Sess. 535 (1970) [hereinafter cited as *1970 Hearings*]) and also in recognition of the fact that it is often difficult to tell the difference between senility and mental illness (110 Cong. Rec. 21349 (1964) (remarks of Sen. Carlson)). Importantly, however, Congress imposed specific standards designed to ensure that the aged mentally ill received treatment appropriate to their needs. See 42 U.S.C. 1396a(a)(20) and (21).

Congress's next major break from the blanket prohibition against funding for the mentally ill came in 1972 when it authorized Medicaid coverage for persons under age 21 receiving inpatient psychiatric services. Congress took this step in recognition of the fact that short-term

treatment, if provided at an early enough age, is "a more efficient investment and has greater potential" for success than treatment for older persons. 1970 Hearings 534. Again, however, Congress imposed specific restrictions on reimbursement for the treatment of mentally ill children to ensure that such treatment was in fact beneficial and cost-effective. In order to be eligible for Medicaid coverage, the child-patient must be receiving active treatment that can reasonably be expected to improve the patient's condition, such that the services will eventually become unnecessary. 42 U.S.C. 1396d(h). Once more, Congress's concern for the protection of the public fisc is evident.

In the case of the mentally ill between the ages of 21 and 64, on the other hand, Congress has never taken any affirmative action to provide blanket Medicaid coverage for the treatment of their mental conditions. In light of Congress's demonstrated concern for cost-effectiveness in the case of the elderly and those under 21, it would be surprising indeed to conclude that Congress intended open-ended funding for those between the ages of 21 and 64, without regard to the efficacy of the treatment, simply because the patients were residing in facilities other than traditional mental hospitals. Such a result is all the more improbable in light of the fact that Congress has, in the Community Mental Health Centers Act and the block grant program of which it is now a part (see note 31, *infra*), provided for the treatment of the chronically mentally ill without regard to age. Under that program, however, Congress again took pains to specify standards designed to ensure therapeutic and cost-effective treatment. 42 U.S.C. 300x-4(c)(5). Although the Medicaid program contains general standards that ICFs and SNFs must meet, conspicuously absent from the statute is any specific provision for therapeutic and cost-effective treatment of mental illness in such facilities. Such an omission should not be attributed to congressional inadvertence in light of Congress's demonstrated concern with efficacy and cost-effectiveness in other mental illness programs.

Moreover, the potential cost to the federal government that would flow from acceptance of Connecticut's argument is staggering. In the consolidated decision of the Departmental Grant Appeals Board in this action (Pet. App. 1d-61d), over \$9 million in disallowances was at stake for 18 facilities in four states over a two-year period. HHS advises us that there are hundreds of ICFs around the country that should be audited to determine whether their "overall character" is that of an IMD. If even a fraction of these audits resulted in such a determination, but the Secretary were required to reimburse the states in any event, the federal financial burden obviously would be enormous. In the absence of any affirmative indication that Congress meant to undertake such a substantial obligation, this Court should defer to the reasonable interpretation of the Secretary that gives full effect to Congress's step-by-step expansion of federal financial assistance for the mentally ill. See *Schweiker v. Wilson*, 450 U.S. 221, 238-239 (1981).

It is also true that Congress's original reluctance to provide any funding for the mentally ill stemmed from its perception (perhaps accurate at the time) that state mental institutions were not providing therapeutic treatment but instead did little more than furnish custodial care in dismal surroundings. But that is no longer the situation today. Significant improvements have been made in the treatment provided by large mental hospitals. See pages 35-36, *infra*. Notwithstanding these welcome changes, Connecticut does not dispute the fact that the IMD exclusion remains fully applicable for persons aged 21 to 64 receiving services in traditional mental hospitals. See Pet. Br. 6. If, as Connecticut argues, Congress wanted to avoid paying only for non-therapeutic custodial care, then it is reasonable to assume that Congress would have lifted or relaxed the IMD exclusion insofar as it applies to traditional mental hospitals, at least to a degree commensurate with the improvement in treatment now offered by those facilities. That it has not, despite several requests to do so (see pages 30-31, *infra*), is persuasive

evidence that the Secretary's interpretation of the statute is correct.

II. A. Policy considerations aside, the plain language of the statute supports the Secretary's interpretation of the IMD exclusion. In defining "medical assistance" for which Medicaid reimbursement is available, the statute lists separately "inpatient hospital services," "intermediate care facility services," and "skilled nursing facility services," and contains a separate and unequivocal exclusion from *each* type of service for individuals in IMDs. 42 U.S.C. 1396d(a)(1), (4)(A), and (15). If Congress had intended to limit IMDs to mental hospitals, there would have been no reason to exclude IMDs from the definitions of covered services in other types of facilities. Moreover, Congress expressly used the term "psychiatric hospital" when it intended to refer to a traditional mental hospital. 42 U.S.C. 1396d(h). That it did not do so in the IMD exclusion is strong evidence that the Secretary's focus on the "overall character" of an institution, rather than its label, is precisely what Congress intended.

B. The legislative history of the IMD exclusion fully supports the Secretary's interpretation of the statute. Connecticut relies almost entirely on legislative history demonstrating Congress's intent to lift the IMD exclusion for the *elderly*, a point not at issue in this litigation. The absence of any comparable legislative history with respect to the mentally ill between the ages of 21 and 64 is fatal to Connecticut's argument, especially in light of the fact that Congress declined on three separate occasions to extend the same benefits to those under 65 that it had already provided for the elderly.

C. There is no merit to Connecticut's contention that in the years after Medicaid was first enacted the Secretary interpreted the IMD exclusion as being limited to traditional mental hospitals. From the beginning, the Secretary has identified IMDs by looking to the "overall character" of an institution to determine whether it is engaged primarily in the care and treatment of the mentally ill. The Secretary's consistently-held functional

approach, rather than Connecticut's mechanical labeling of facilities, best comports with congressional intent.

III. A. Connecticut's argument that the disallowance at issue contravenes the principles of "federalism" that underlie the Medicaid program is not properly before this Court. Connecticut's petition for a writ of certiorari raised a single issue—whether, as a matter of statutory construction, the IMD exclusion is limited to traditional mental hospitals. Accordingly, the Court should not consider Connecticut's new contention that the challenged disallowance is an "after-the-fact" action that is inconsistent with the federal-state "contract" created by the Medicaid program.

B. Even if Connecticut's new argument had been properly preserved, it is erroneous. There is no merit to the assertion that the Secretary's interpretation of the IMD exclusion took Connecticut by surprise. In addition to the Secretary's long-standing regulation defining IMDs in terms of their "overall character," Connecticut itself admits (Br. 95 n.74) that it became aware of the Secretary's position in 1976, *i.e.*, before it incurred the expenditures at issue in this litigation. Nor is there any impropriety in the Secretary's retroactive disallowance of nonreimbursable expenditures. On the contrary, the Medicaid statute expressly directs the Secretary to conduct post-expenditure audits to ensure that funds previously advanced to the states were properly spent. If they were not, the Secretary is required to recoup the misspent funds. 42 U.S.C. 1396b(d)(1) and (5). Thus, the Secretary followed precisely the course mandated by Congress. See *Bell v. New Jersey*, 461 U.S. 773, 780-783 (1983).

ARGUMENT

I. THE TERM "INSTITUTION FOR MENTAL DISEASES" IS NOT LIMITED TO LARGE, TRADITIONAL MENTAL HOSPITALS

It is undisputed that the Medicaid statute prohibits federal reimbursement for services to individuals over age 21 and under age 65 who are patients in an "institution

for mental diseases" (IMD). 42 U.S.C. 1396d(a).¹² Congress did not define the term "IMD," but it did give the Secretary of HHS broad discretion to interpret and administer the statute. 42 U.S.C. 1302. As this Court has noted, the "Social Security Act is among the most intricate ever drafted by Congress." *Schweiker v. Gray Panthers*, 453 U.S. 34, 43 (1981). For that reason, especially heightened deference is due the Secretary's interpretation of the Act. *Id.* at 43-44.¹³ As we demonstrate below, the Secretary's conclusion that ICFs and IMDs are not mutually exclusive is a wholly rational interpretation of the statute that should be upheld by this Court.

¹² This Court has upheld the constitutionality of this prohibition. See *Legion v. Richardson*, 354 F. Supp. 456 (S.D.N.Y.), *aff'd sub nom. Legion v. Weinberger*, 414 U.S. 1058 (1973); see also *Schweiker v. Wilson*, 450 U.S. 221 (1981); *Kantrowitz v. Weinberger*, 388 F. Supp. 1127 (D.D.C. 1974), *aff'd*, 530 F.2d 1034 (D.C. Cir.), *cert. denied*, 429 U.S. 819 (1976).

¹³ Although the Medicaid statute does not expressly delegate to the Secretary authority to define IMDs (compare *Schweiker v. Gray Panthers*, 453 U.S. at 43-44), the absence of a statutory definition necessarily required action by the Secretary to fill the void left by Congress. Such action was authorized by 42 U.S.C. 1302, which directs the Secretary to promulgate rules and regulations necessary to the efficient administration of the Social Security Act. We submit that the extraordinary complexity of the statute requires reviewing courts to give greater deference to the Secretary's interpretations under this general rulemaking authority than might be the case with a more straightforward statute. See *Board of Governors of Federal Reserve System v. Investment Co. Institute*, 450 U.S. 46, 56 & n.21 (1981). In any event, so long as the agency's interpretation of the statute is a reasonable one, a court may not substitute its own construction for that of the agency. See *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, No. 82-1005 (June 25, 1984), slip op. 4-7.

Connecticut's argument (Br. 108-118) that no deference is owed to the Secretary's interpretation in this case because that interpretation represents a change in position and is contrary to congressional intent is erroneous. See pages 35-43, *infra*.

A. The Secretary's Interpretation Of The Term "IMD" Is Supported By The Plain Language Of The Statute

1. "[T]he starting point for interpreting a statute is the language of the statute itself." *Consumer Product Safety Commission v. GTE Sylvania, Inc.*, 447 U.S. 102, 108 (1980).¹⁴ Although the Medicaid statute does not define the term "institution for mental diseases," the manner in which Congress used that term throughout the statute demonstrates that Congress did not intend IMDs and ICFs to be mutually exclusive or to limit IMDs to traditional mental hospitals. On the contrary, the statutory IMD exclusion clearly encompasses other types of institutions providing services primarily to the mentally ill, including ICFs and SNFs.

a. In defining medical assistance for which Medicaid reimbursement is available, the statute lists separately "inpatient hospital services," "intermediate care facility services," and "skilled nursing facility services," and contains a separate and unequivocal exclusion from *each* type of service for individuals in IMDs. 42 U.S.C. 1396d(a)(1), (4)(A), and (15). The statute clearly excludes Medicaid reimbursement for services in IMDs for *each* type of facility, not just hospitals. By listing hospital services separately from SNF and ICF services, and excluding each type of service in an IMD, Congress necessarily stated in Section 1396d(a) that a particular ICF or SNF can, under some circumstances, also be an IMD. As the court of appeals observed (Pet. App. 9a-10a), if IMDs referred only to hospitals, there would be no reason

¹⁴ Connecticut purports to agree with this well-settled principle (Br. 29). Nevertheless, virtually all of Connecticut's argument focuses on legislative history, rather than the language of the statute. Indeed, Connecticut's first argument is a lengthy exegesis of the legislative history of the IMD exclusion going back to 1950, when ICFs did not even exist (Br. 24-49). Moreover, as we show in Point I(B), *infra*, the legislative history upon which Connecticut relies does not support its reading of the statute.

to exclude IMDs from the definitions of other types of covered services. The statutory language could hardly be more clear.

If the language of Section 1396d(a)(1), (4)(A), and (15) were not sufficient, other sections of the statute repeat the IMD exclusion in terms that make clear its applicability to all types of institutions. For example, 42 U.S.C. 1396d(a)(B) contains a blanket prohibition on medical assistance payments for services to individuals under age 65 who are patients in an IMD, thereby reinforcing the plain meaning of the specific exclusions contained in Section 1396d(a)(1), (4)(A), and (15). Moreover, at the same time that Section 1396d(a)(B) *excludes* from Medicaid coverage care or services in IMDs for those under 65, 42 U.S.C. 1396d(a)(14) *includes* services for those over 65 by authorizing Medicaid coverage for:

inpatient hospital services, skilled nursing facility services, and intermediate care facility services for individuals 65 years of age or over in an institution for mental diseases.¹⁵

If Congress had intended to limit IMDs to traditional mental hospitals, it would have provided simply that persons over age 64 were eligible for Medicaid coverage in IMDs. Connecticut's contention that IMDs can only be mental hospitals makes the reference to "inpatient hospital services" in Section 1396d(a)(14) surplusage, and at the same time it renders meaningless Congress's separate authorization for SNF and ICF services for the elderly in IMDs. Connecticut thus asks the Court to ignore the elementary principle of statutory construction that requires courts to give effect to every word that Congress has used. See, e.g., *Reiter v. Sonotone Corp.*, 442 U.S. 330, 339 (1979).

b. Equally significant is the fact that Congress knows how to identify a traditional mental hospital in un-

¹⁵ When this section was first enacted, the term "ICF" was not yet in use. In the Social Security Amendments of 1972, Pub. L. No. 92-603, § 297, 86 Stat. 1459-1460, the reference to ICF services was added to Section 1396d(a)(14).

mistakable terms and has done so in another section of the Medicaid statute. By amendment to the Act in 1972, Congress included within the definition of "medical assistance" for which federal financial participation is authorized "inpatient psychiatric hospital services for individuals under age 21" (42 U.S.C. 1396d(a)(16)). The Act defines "inpatient psychiatric hospital services" as "inpatient services which are provided in an institution which is accredited as a *psychiatric hospital* by the Joint Commission on Accreditation of Hospitals" (42 U.S.C. 1396d(h) (emphasis added)). If Congress had thought that IMDs were limited to traditional mental hospitals, there would have been no need for it to refer specifically to psychiatric hospitals because those hospitals would have been the only type of facility embraced within the IMD concept throughout the more than 20 years that Congress had been employing the term. Under traditional principles of statutory construction, therefore, Congress's deliberate choice of the term "psychiatric hospital" in Section 1396d(a)(16) compels the conclusion that the term IMD is not limited to traditional mental hospitals. See, e.g., *Lawrence County v. Lead-Deadwood School Dist.* No. 40-1, No. 83-240 (Jan. 9, 1985), slip op. 10; *Fedorenko v. United States*, 449 U.S. 490, 512 (1981).

2. a. Connecticut does not point to a single section of the Medicaid statute that refutes the plain meaning of the sections described above. Instead, while conceding that the Act does not define IMDs, Connecticut argues that the statute contains "an express statement of what that term [IMD] does *not* include" (Br. 51-52 (emphasis in original)). Connecticut's argument is that 42 U.S.C. 1396a(a)(21)—part of the so-called "Long Amendment"—expressly prohibits ICFs from also being classified as IMDs because that provision "defines" nursing facilities (as well as community mental health centers) as "alternatives" to public IMDs.¹⁶ Contrary to Connecticut's asser-

¹⁶ The Long Amendment (named after Senator Long, then-Chairman of the Senate Finance Committee) actually consists of three sections of the original Medicaid statute enacted in 1965. The

tion, however, Section 1396a(a)(21) nowhere defines the term "nursing facilities." The most that can be said for this section, therefore, is that not every nursing home is a public IMD, a proposition the Secretary has never disputed. But Section 1396a(a)(21) furnishes no basis for concluding that "nursing facilities" and public IMDs, even though presumably different in many respects, are always mutually exclusive types of facilities. The real question, which Section 1396a(a)(21) does not even begin to address, is whether certain nursing facilities exhibit the "overall character" (42 C.F.R. 435.1009(e)) of an IMD.¹⁷

b. In the absence of any statutory provision that supports its position, Connecticut presents two principal arguments intended to overcome the force of the statutory language contained in 42 U.S.C. 1396d. Neither argument is persuasive.

first section, 42 U.S.C. 1396d(a)(14), authorized Medicaid coverage for the elderly in IMDs. The other two provisions of the Long Amendment were the conditions Congress attached to Medicaid coverage for the elderly in IMDs (see page 4, *supra*). Briefly summarized, 42 U.S.C. 1396a(a)(20) provides that if a state chooses to include in its state plan medical assistance for the elderly in IMDs, the state must develop other forms of care for the aged mentally ill and conduct initial and periodic reviews of each elderly patient to ensure appropriate treatment for each individual. The final provision of the Long Amendment, 42 U.S.C. 1396a(a)(21), provides that if a state chooses to include in its state plan medical assistance for the elderly who are patients in public IMDs, the state must show that it is making satisfactory progress toward developing and implementing a comprehensive mental health program, "including provision for utilization of community mental health centers, nursing facilities, and other alternatives to care in public institutions for mental diseases." It is this last component of the Long Amendment that we discuss above in text.

¹⁷ In addition, Section 1396a(a)(21) refers to "nursing facilities" as alternatives to care in "public institutions for mental diseases"; it is undisputed, however, that the IMD exclusion covers, at a minimum, private as well as public mental hospitals. See Pet. Br. 54-55 n.41. Thus, even if Connecticut's argument that the statute expressly states what an IMD is not were sufficient to overcome the clear statutory provisions previously cited, Section 1396a(a)(21) cannot be used to show that nursing facilities and *private* IMDs are mutually exclusive.

i. Connecticut contends (Br. 56-59) that the statutory definition of an ICF (42 U.S.C. 1396d(c)) supersedes the blanket IMD exclusion (42 U.S.C. 1396d(a)(B)) and authorizes Medicaid coverage for all ICF patients because the former was enacted after the latter and specifically includes care offered to patients who require it "because of their *mental* or physical condition." 42 U.S.C. 1396d(c)(1) (emphasis added). Connecticut forgets that the Secretary's interpretation of the statute does not require treating an ICF as an IMD simply because it provides mental health care to some patients; again, the focus is on the "overall character" of the facility (42 C.F.R. 435.1009(e); see Pet. App. 8a). An ICF the "overall character" of which is *not* indicative of an IMD might well provide treatment for mental conditions to patients requiring such treatment, and the facility could receive reimbursement for such services. But certain ICFs, because of their overall character, also may be IMDs. In the case of such hybrid institutions, 42 U.S.C. 1396d(a)(B) prohibits federal reimbursement for services rendered to individuals between the ages of 21 and 64.¹⁸

In addition, Connecticut's reliance on Section 1396d(c)'s reference to patients needing ICF care because of their mental condition is susceptible to an interpretation that fully comports with the Secretary's reading of the statute. If a state has chosen to extend Medicaid coverage to persons age 65 and over in IMDs (see 42 U.S.C. 1396a(a)(10), (20), and 21),¹⁹ such persons are covered for mental conditions regardless of whether treatment is provided in a hospital, an SNF, or an ICF. See 42 U.S.C. 1396d(a)(14). Thus, as the court of appeals concluded

¹⁸ Connecticut's "later-in-time" argument (Br. 56-57) suffers from another defect as well. The later-enacted ICF definition on which Connecticut relies (42 U.S.C. 1396d(c)) itself includes an IMD exclusion, as does Section 1396d(a)(15). The ICF provisions of the statute thus parallel, rather than supersede, the blanket IMD exclusion contained in Section 1396d(a)(B).

¹⁹ In the period at issue here, Connecticut did not elect to extend coverage to such persons. See J.A. 24a.

(Pet. App. 8a), the language in Section 1396d(c) most probably refers to aged patients with mental illness. By the same token, the statute clearly provides coverage for the treatment of the mentally retarded in public ICFs, 42 U.S.C. 1396d(d), and the language also may apply to patients in this category (see Pet. App. 8a). In any event, the important point is that Congress nowhere expressed an intention to extend Medicaid coverage to ICFs that are engaged *primarily* in the care or treatment of the mentally ill under age 65.

ii. Connecticut's sole alternative to the ineluctable conclusion to be drawn from the plain language of the statute—that under certain circumstances an ICF can be classified as an IMD—is to draw an artificial distinction between an ICF operated *independently* of an IMD and an ICF *connected* with an IMD. Connecticut contends (Br. 53) that so long as ICF-level services are offered in independent, or “free-standing,” ICFs, Congress intended that Medicaid funds be available. Only if states seek to obtain Medicaid reimbursement for ICF-level services provided in traditional mental hospitals would Connecticut concede the applicability of the IMD exclusion. For a number of reasons, this interpretation is plainly wrong.

First, as the court of appeals noted, Connecticut asks the Court to believe that, “while Congress intended to encourage the use of ICF's, it expressly forbade financial assistance to effect even the partial transformation of state mental hospitals into ICF's” (Pet. App. 9a). In support of this interpretation, Connecticut stresses Congress's desire to deemphasize reliance on traditional state mental hospitals (Br. 60-68). But this argument proves too much. As much as Congress may have looked with disfavor upon state mental institutions, there is nothing to indicate that Congress thought they could be entirely replaced by “alternative” facilities. Yet Connecticut's argument has the effect of attributing to Congress an intent to perpetuate the dismal conditions often found in state mental institutions by creating financial disincentives to their improvement. As the court of appeals emphasized

(Pet. App. 9a), “transforming part of an existing facility [into an ICF] might be considerably less expensive than development of a new institution.” Connecticut's interpretation of the IMD exclusion would make this sort of cost-effective improvement sufficiently unattractive that few states would consider that option.

Second, the distinction proffered by Connecticut treats an ICF operated within an IMD differently from an independent ICF even though the nature of the patients treated and services offered are identical. Connecticut offers not the slightest support for the notion that Congress intended such an artificial distinction, which leads to wholly incongruous results. For example, Connecticut's interpretation requires the conclusion that a free-standing ICF or SNF offering solely psychiatric services to 100% of its patients at SNF or ICF levels of care can never be an IMD. Conversely, a traditional mental hospital, even if it provided only SNF or ICF services to all of its patients, could never be treated as an SNF or ICF. This single-minded focus on facilities, rather than the nature of the patients and the treatment they are receiving, has no basis in logic.

Third, Connecticut's interpretation would permit states to make a complete end-run around the IMD exclusion. States would be free to shift the burden of funding to the federal government merely by effecting wholesale transfers of mentally ill patients from larger institutions into smaller institutions that perform the same functions.²⁰ Indeed, the audit team in the instant action determined that “the State of Connecticut has been discharging large numbers of mentally ill patients from State mental institutions into skilled nursing facilities (SNF's) and inter-

²⁰ Connecticut argues (Br. 114) that the Secretary's concern over inappropriate patient transfers is unjustified because 42 U.S.C. 1396a(a)(20)(A) (part of the Long Amendment, described at note 16, *supra*) requires states to provide “assurance of immediate readmittance to institutions where needed for individuals under alternate plans of care.” As with virtually all of Connecticut's arguments, however, this provision deals only with the

mediate care facilities (ICF's)" (J.A. 6a).²¹ Even assuming that Congress has expressed a preference for ICFs over traditional mental hospitals, it has never suggested that it meant to permit the states to escape their longstanding responsibility for the care of the mentally ill simply by shifting their patient populations from bigger institutions to smaller ones.²²

elderly. See S. Rep. 404, *supra*, at 145 (emphasis added) ("The committee is aware that not always does a discharge plan work out to the best advantage of the patient, and thus the committee's bill provides that the agreement must make provision for the prompt readmittance to the institution where needed for the *aged person* who has been placed under an alternate plan of care."). See also pages 29, 32-33, *infra*.

²¹ See also the testimony of Dr. Lawrence W. Osborne before the Departmental Grant Appeals Board given in response to a question from Connecticut's counsel as to whether Connecticut's interpretation of the IMD exclusion would result in "dumping" patients in ICF-type facilities in order to obtain federal matching funds (4/23/81 Tr. 366-367):

I am not sure you will like the answer. * * * Conversations with the former commissioner—it is both my knowledge and judgment that Connecticut deliberately—deliberately placed people out in state psychiatric hospitals into other facilities for economic purposes—and quality care.

I have absolutely no problem with the state wanting to maximize [federal financial participation]. At least, however, as a by-product of that, don't tell me quality care is in even more danger than it was in the psychiatric hospital. That was not the case in Middletown Rest Haven, but it is the case in other facilities.

²² We note also that the frustration of congressional intent caused by patient-shifting need not be the product of state efforts to obtain federal funding to which they are not entitled. States may well conclude that transferring patients from mental hospitals to different types of facilities is in the best interests of their own mentally ill citizens, but they cannot expect federal financial support for such transfers in the absence of affirmative authorization from Congress. As Congress has long recognized, the states bear primary responsibility for the care of their mentally ill citizens.

B. The Legislative History Fully Supports The Secretary's Interpretation Of The IMD Exclusion

If any doubt remains as to the meaning of the IMD provisions of the Medicaid statute, "that doubt is removed by the legislative history." *Bankamerica Corp. v. United States*, No. 81-1487 (June 8, 1983), slip op. 11. We have previously traced the development of the IMD exclusion from 1950 to the present (see pages 3-6, *supra*). The point that emerges from that development is Congress's cautious, step-by-step approach to increased federal funding for the mentally ill. What further emerges from the legislative history is that Congress has not yet taken the step of authorizing Medicaid coverage for SNFs and ICFs primarily engaged in the care and treatment of the mentally ill under age 65.

1. Connecticut relies heavily (Br. 24-29, 60-71) on legislative history demonstrating Congress's intent to encourage the development of alternatives to traditional mental hospitals. That history, however, is drawn almost entirely from congressional consideration of the original IMD exclusion as it pertained to the *elderly*. As the court of appeals recognized, Connecticut's lengthy discussion of the legislative history concerning alternative types of care for the elderly "merely underlines the absence of any such history supporting Connecticut's position as to persons *under age 65*" (Pet. App. 12a (emphasis added)). In addition, congressional consideration of alternative types of care for the elderly occurred in connection with Congress's decision to lift the IMD exclusion for the elderly entirely, so that they are now eligible for mental health treatment in all types of facilities (*e.g.*, hospitals, SNFs, or ICFs). See 42 U.S.C. 1396d(a)(14); S. Rep. 404, *supra*, at 145. The absence of any similar discussion with respect to persons under age 65, coupled with Congress's failure to alter the IMD exclusion for those under age 65, is fatal to Connecticut's argument.²³

²³ Moreover, the fact that the ICF concept did not enter the legislation until 1967 completely undercuts Connecticut's reliance

2. The hole in Connecticut's argument cannot be attributed to mere legislative inadvertence. On the contrary, Congress has on at least three occasions rejected explicit proposals to lift the IMD exclusion for persons under age 65. Significantly, the proposals would have made Medicaid funding available for the needy mentally ill under age 65 not simply in traditional mental hospitals, but also in alternative treatment settings. See, e.g., *Social Security Amendments of 1967: Hearings on H.R. 12080 Before the Senate Comm. on Finance*, 90th Cong., 1st Sess. 1741 (1967) (statement of Dr. Robert W. Gibson, American Psychiatric Ass'n) [hereinafter cited as *1967 Hearings*]; ²⁴ *Social Security Amendments of 1970: Hearings on H.R. 17550 Before the Senate Comm. on Finance*, 91st Cong., 2d Sess. 500-550 (1970) [hereinafter cited as *1970 Hearings*]; *Social Security Amendments of 1971: Hearings on H.R. 1 Before the Senate Comm. on Finance*, 92d Cong., 1st & 2d Sess. 924-941 (1972) (statements of Dr. Jonathan Leopold, Comm'r, Vt. Dept. of Mental Health, and Dr. Kenneth Gaver, Comm'r, Ohio Dept. of Mental Hygiene & Corrections) [hereinafter cited as *1972 Hearings*].

on the pre-1967 legislative history. To the extent that Connecticut relies on the numerous references to mental hospitals in that pre-1967 period, it is clear that those references merely confirm that a state mental hospital is an IMD—a fact clearly not at issue here and certainly not inconsistent with the notion that an ICF also can be an IMD.

²⁴ Dr. Gibson urged Congress to make Medicaid funding available for those under age 65 in public mental hospitals, private psychiatric hospitals, and community mental health centers. Dr. Gibson stressed the need for coverage at all "properly qualified institutions" and explained how this would be accomplished (*1967 Hearings* 1742):

We want the definition of a hospital to include the public mental hospital, the private psychiatric hospital, and the community mental health center.

This would mean deleting the phrase "other than services in an institution for * * * mental diseases."

Congress did not adopt Dr. Gibson's suggestion.

The court of appeals discussed the significance of these hearings at length (see Pet. App. 12a-15a). It is sufficient to note here that Congress was urged to authorize Medicaid coverage for the mentally ill under age 65 not only in mental hospitals but in ICFs as well. See *1970 Hearings* 502 ("A program of care is needed at a level below that of a medically-oriented skilled nursing home. For the mentally ill this might be a supportive program of care of a semimedical nature."); see also *id.* at 505-506. As the court of appeals observed, "[t]his episode * * * suggests two conclusions: (1) Congress did not consider ICF's and IMD's as mutually exclusive categories; and (2) Congress declined to enact an ICF definition which included ICF's treating the mentally ill, although it was explicitly asked to do so" (Pet. App. 13a).

3. In addition to Congress's three post-1965 rejections of proposals to lift the IMD exclusion for the mentally ill under age 65, the legislative history of the 1972 amendments to the Medicaid program makes clear that Congress's reference to ICF services was to such services *provided in ICFs*, and not just to such services provided in traditional mental hospitals. As previously noted (see note 15, *supra*), in the Social Security Amendments of 1972, Pub. L. No. 92-603, § 297, 86 Stat. 1459-1460, codified at 42 U.S.C. 1396d(a)(14), Congress authorized Medicaid funding for ICF services for the elderly in IMDs. The Conference Report explained this amendment as follows (H.R. Rep. 92-1605, 92d Cong., 2d Sess. 64 (1972) (emphasis added)):

The Senate amendment added a new section to the House bill which provided that when a State chooses to cover individuals age 65 and over in institutions for * * * mental diseases it *must cover such care in intermediate care facilities as well as in hospitals and skilled nursing homes.*

This passage clearly indicates that all three types of facilities—hospitals, SNFs, and ICFs—can be IMDs. The language demonstrates that Congress contemplated hybrid institutions such as Middletown Haven—institutions that,

by virtue of their overall character, are simultaneously ICFs and IMDs. If Congress had intended to limit IMDs to mental hospitals, the Conference Report would not have referred separately to each type of facility.

4. Even though Congress rejected three post-1965 proposals to lift the IMD exclusion for the mentally ill under age 65, Connecticut apparently contends that Congress actually took such action in the original Medicaid legislation passed in 1965. Connecticut again relies heavily (Br. 43-45) on the Long Amendment. As we have previously noted (see note 16, *supra*), the Long Amendment, as a condition of providing federal financial assistance for the elderly in IMDs, required participating states to demonstrate satisfactory progress in the development of comprehensive mental health programs. The legislative history of the Long Amendment plainly indicates, however, that Congress's concern was, again, with the development of alternative treatment plans for the *elderly*. The Senate Report explained the Long Amendment as follows (S. Rep. 404, *supra*, at 145-146 (emphasis added)):

For those States that wish to take advantage of Federal participation in payments to the mentally ill who are in institutions for mental disease, the bill requires a provision for a joint agreement * * *. This agreement is intended * * * to set forth alternative methods of care, *particularly for the aged who are mentally ill*. Institutional treatment and care in the individual's own home are only two of the possible ways of caring for the *aged* who have mental problems. It is expected that the joint agreements will include plans for the use of other methods of care, such as nursing homes, short-term care in general hospitals, foster family care, and others. This legislation, it is anticipated, will give further encouragement to the trend in the States for discharging from mental hospitals to the community the *aged* who are considered able to care for themselves, under some form of protective arrangements. * * *

* * *

The committee bill provides for the development in the State of alternative methods of care and requires that the maximum use be made of the existing resources in the community which offer ways of caring for the mentally ill who are not in hospitals. This is intended to include provisions for persons who no longer need care in hospitals and who can, with financial help and social services to the extent needed, make their way in the community. Under the 1962 Public Welfare Amendments, State public welfare agencies are encouraged to provide social services for the *aged* * * *. Under the committee bill, these social services would be made available, as appropriate, for the *aged* who are in the hospitals or who would otherwise need care in an institution.^[25]

Given this clear congressional understanding that the Long Amendment dealt only with the needs of the elderly mentally ill, it is inconceivable that Congress would have authorized identical coverage for those under age 65 without ever saying so.

²⁵ Significantly, mental health professionals also understood that the Long Amendment dealt only with the elderly. See 1970 *Hearings* 541 (remarks of Dr. Jonathan Leopold, Vt. Comm'r of Mental Health) (emphasis added)):

The Long amendment was very farsighted in the variety of approaches and requirements for cooperation, for program planning, for individual planning, for progress in program and programs. *But it was restricted solely to the old age assistance recipients* and, as you know, Senator, there are many, many persons under the age of 65 who are presently disabled who fit into the aid to the permanently and totally disabled category who would also benefit from such an improvement in program as well as many, needy children.

Similarly, in testifying about the perceived success of the Long Amendment, which authorized Medicaid coverage for the elderly mentally ill in all types of facilities, Dr. Leopold stated that "[t]hese [elderly] patients have been discharged into nursing homes, into intermediate-care facilities, into boarding homes, foster homes, family care, and many of them to return to live with their own families; and we think this is a very impressive record as a result of this legislation [the Long Amendment]" (1972 *Hearings* 928). Dr. Leopold then urged Congress to extend comparable cover-

Connecticut also relies (Br. 69) on a statement made by Senator Long in support of the 1971 legislation transferring ICF coverage to the Medicaid program (see page 5 & note 4, *supra*). Senator Long stated that "intermediate care coverage is for persons with health-related conditions who require care beyond residential care or boarding home care, and who, in the absence of intermediate care would require placement in a skilled nursing home or mental hospital." 117 Cong. Rec. 44721 (1971) (citation omitted). Connecticut contends (Br. 69-70) that Senator Long's statement demonstrates Congress's intent that Medicaid funding be available for ICF services provided to all patients who otherwise would be in a mental hospital subject to the IMD exclusion. But Connecticut conveniently ignores a significant portion of Senator Long's statement. The statement described ICF care as being not only for those who would otherwise be in a mental institution, but also for those who would otherwise be in a skilled nursing home. Yet it has been Connecticut's position throughout this litigation that the IMD exclusion is as inapplicable to "free-standing" SNFs as it is to "free-standing" ICFs. Thus, Senator Long's statement simply does not support Connecticut's argument.²⁶

5. The import of the legislative history is clear. The IMD exclusion was intended to block the use of Medicaid funds to help pay for the care of the mentally ill under age 65 in a broad range of institutions subsumed under the label "institution for mental diseases," including ICFs. Congress was asked repeatedly to lift the exclusion, but it has declined to do so. In these circumstances, it would be inappropriate indeed to provide Connecticut with the relief it seeks through litigation when the states have been unable to obtain that relief from Congress. See *United States v. New Mexico*, 455 U.S. 720, 744 (1982).

age to the mentally ill under age 65. *Id.* at 928-929; see also Pet. App. 13a-14a.

²⁶ In addition, as we have demonstrated above (see pages 32-33, *supra*), Senator Long's amendment dealt with ICF services for the elderly and thus not subject to the IMD exclusion in any event.

C. The Secretary's Interpretation Of The IMD Exclusion Is Entitled To Deference

Despite the clear import of the statutory language and the legislative history, Connecticut argues (Br. 108-118) that the Secretary's interpretation of the IMD exclusion should be disregarded because it is allegedly inconsistent with congressional intent and because HHS allegedly has not adhered to a consistent administrative interpretation of the IMD exclusion. Neither contention is correct.

1. Connecticut contends that the Secretary's interpretation of the IMD exclusion conflicts with congressional intent because Congress actively sought to promote the use of "alternatives" to traditional mental hospitals, while the Secretary's interpretation would eliminate any incentive to develop alternatives such as ICFs and SNFs by making Medicaid coverage unavailable for patients in ICF/IMDs or SNF/IMDs. Connecticut's argument is flawed for a number of reasons.

First, traditional mental hospitals are no longer the "dumping grounds" Congress sought to discourage, a fact of which this Court has taken notice. *Pennhurst State School & Hospital v. Halderman*, No. 81-2101 (Jan. 23, 1984), slip op. 18 n.16. Both public and private mental hospitals now provide active, therapeutic treatment for their patients, and custodial, room and board "care" is largely a thing of the past. Indeed, as early as 1970, Congress was told that "[m]odern state mental hospital services are not custodial but, rather, are treatment-oriented to the limit of their resources." 1970 *Hearings* 511 (statement of Dr. Gaver). Similarly, Dr. Leopold told the Senate Finance Committee that "[y]our committee has heard about 'human warehouses,' and many of our State hospitals were such places. They are no longer." *Id.* at 532. Mr. Schnibbe, the Executive Director of the National Association of State Mental Health Program Directors, explained the improvements in greater detail (*id.* at 538):

The notion that the States as a whole are still operating custodial facilities is fallacious.

Now, it still persists in places. Both of these doctors here today would probably say they know of a couple of instances around the country where it is still true.

The point is that right now this is generally a fallacious notion.

* * * * *

It might have been true 30, 40, 50 years ago. It is not true today because some of the finest, most progressive, most exciting mental hospitals are State-operated programs in Little Rock, Ark., and Denver, Colo., and other State facilities all over the country.

See also Br. of Amici Curiae Illinois, California & Minnesota 8; 1970 Hearings 539-541; M. Levine, *From State Hospital to Psychiatric Center* (1980); Ahmed, *Whither the State Hospital? Issues and Trends in Mental Health Services Delivery*, in *State Mental Hospitals* 208 (P. Ahmed & S. Plog ed. 1976); H. Gottesfeld, *Alternatives to Psychiatric Hospitalization* 23-34 (1977).²⁷

With these improvements in the treatment offered to patients at traditional mental hospitals—improvements that were brought to Congress's attention over a decade ago—it is reasonable to assume that Congress would have acted to lift or relax the IMD exclusion insofar as it applies to mental hospitals, at least to a degree commensurate with the improvement in treatment now offered by those facilities. That it has not done so strongly suggests that Congress's concern extended beyond distrust of the old state mental institution and embraced fiscal considerations to at least an equal degree. Connecticut's crabbed interpretation of the IMD exclusion would totally undermine Congress's concern for the public fisc. If such a large, additional expenditure of public monies is to be undertaken, it should occur only as the result of clear congressional authorization.²⁸

²⁷ The last-cited book contains a table (H. Gottesfeld, *supra*, at 34) showing the changes in mental hospitals from the 1950's to the 1970's. The table is reproduced as Appendix B to this brief.

²⁸ That Congress is fully capable of responding to changed circumstances if it so chooses is amply demonstrated by the Medicare

Second, while we do not dispute Congress's desire to replace (where appropriate for the patient) outdated traditional mental hospitals with newer, more treatment-oriented and community-based facilities, there is strong evidence to suggest that the move away from mental hospitals into "alternative" treatment settings has not always been as beneficial for patients as had been hoped. The process of transferring patients out of mental hospitals is commonly referred to as "deinstitutionalization." What is less commonly known is the phenomenon of "reinstitutionalization," whereby patients are transferred from state mental hospitals to nursing homes that in fact provide care that is little, if any, better than the custodial care previously offered by mental hospitals.²⁹

and Medicaid Budget Reconciliation Amendments of 1984, Pub. L. No. 98-369, § 2335(f), 98 Stat. 1091. Prior to the passage of this statute, the Medicaid program had excluded coverage (except for those over age 64) in institutions for tuberculosis, as well as in IMDs. The 1984 amendment deleted the tuberculosis exclusion entirely. Although the legislative history of the amendment is quite sparse (see H.R. Rep. 98-861, 98th Cong., 2d Sess. 1327 (1984)), it may reasonably be assumed that Congress was aware both that tuberculosis is less common today than it once was and that it responds to treatment with antituberculosis medication. If Congress had come to a similar conclusion about mental illness, it could have removed the IMD exclusion at the same time that it eliminated the tuberculosis exclusion. That it did not do so undoubtedly reflects Congress's awareness that mental illness shows no signs of abating and that effective short-term treatment remains problematic in significant numbers of cases. For the time being, therefore, it is clear that Congress has chosen to leave primary responsibility for the care of the mentally ill where it always has been—with the states.

²⁹ See, e.g., U.S. Comptroller General, *Rep. No. HRD-76-152, Returning the Mentally Disabled to the Community: Government Needs to Do More* 14, 16 (1977); Goldman, Adams & Taube, *Deinstitutionalization: The Data Demythologized*, *Hospital & Community Psychiatry* 129, 134 (Feb. 1983) (citations omitted) ("Clearly, a large proportion of current nursing home residents would have been state mental hospital patients before deinstitutionalization. However, many observers consider this shift to nursing-home care to be not deinstitutionalization, but reinstitutionalization—a new custodialism replete with its own failures and

If, as Connecticut argues (and we agree), Congress did not want to authorize Medicaid coverage for custodial care of the mentally ill in traditional mental hospitals, then there certainly is no reason to suppose that Congress would have wanted Medicaid funds to go to "alternative" facilities that were no better than the traditional institutions they were replacing.³⁰ In these circumstances, the Secretary's interpretation of the IMD exclusion is fully consistent with congressional intent.

Third, there is no merit to Connecticut's argument (Br. 116-117) that the Secretary's interpretation of the IMD exclusion focuses on the mental diagnoses of a majority of the patients and thereby conflicts with the statutory policy against discrimination in the Medicaid program on the basis of diagnosis (42 U.S.C. 1396a(a)(10)) or the prohibition against discrimination on the basis of

shortcomings.); Stotsky & Stotsky, *Nursing Homes: Improving a Flawed Community Facility*, Hospital & Community Psychiatry 238, 241 (Mar. 1983) (citations omitted) ("A significant number of patients enter nursing homes with psychiatric diagnoses. In fact, psychiatric disturbances are probably the predominant form of illness in nursing homes, and yet psychiatric care in these homes is generally deficient. Dittmar and Franklin found that three years after a group of patients were placed in a nursing home from a state hospital, less than one-third of the group showed adequate mental functioning."); M. Levine, *From State Hospital to Psychiatric Center* 3 (1980) ("Deinstitutionalization and community mental-health programming, initially greeted with enthusiasm, were quickly subject to devastating criticism as journalistic exposes * * * and legislative inquiry * * * uncovered abuses. Patients were released to nursing homes, to board-and-care homes, or to welfare hotels with little planning and little possibility for after-care. This phenomenon, which might have resulted in the premature deaths of some older, frail patients * * *, came to be called 'dumping.'").

³⁰ We recognize that particular facilities, including Middletown Haven, may in fact be offering beneficial treatment to their patients (see, e.g., J.A. 45a-46a). But Congress may reasonably make programmatic judgments concerning the wisdom of funding particular types of facilities, even though certain facilities may not exhibit the general characteristics of the particular category at issue. See *Schweiker v. Gray Panthers*, 453 U.S. at 48; *Schweiker v. Wilson*, 450 U.S. 221, 234-235, 238-239 (1981).

handicap contained in the Rehabilitation Act of 1973, 29 U.S.C. 794. To begin with, the Secretary's regulation and criteria focus on a broad array of factors covering all aspects of a facility, and not merely on the percentage of patients with diagnoses of mental illness. See note 36, *infra*. In addition, neither the regulation nor the criteria work any discrimination based on handicap. The statute states, quite simply, that federal financial assistance is prohibited for services provided in IMDs. Thus, as Connecticut points out (Br. 117), even residents of nursing facilities who are afflicted only with physical disorders are ineligible for Medicaid coverage if they are placed in a facility that is both an ICF and an IMD. The IMD exclusion applies to facilities, rather than to patients (except those over 64), and thus it applies equally to those with mental illness and those without.

This does not mean that the mentally ill are rendered ineligible for Medicaid on the basis of their handicap. Rather, the statute merely limits the types of facilities in which they may receive covered services, much like the certification standards for SNFs and ICFs limit the choice of nursing homes available to Medicaid recipients (see 42 U.S.C. 1395x(j) and 1396d(c)). See generally *O'Bannon v. Town Court Nursing Center*, 447 U.S. 773 (1980). Thus, the eligible mentally ill may receive covered services in a general hospital, general SNF, or general ICF. Similarly, they have access to the full range of outpatient services covered by Medicaid. The only limitation, and the limitation intentionally imposed by Congress, is that Medicaid coverage may not be provided for services in IMDs. To paraphrase this Court's holding in *Schweiker v. Wilson*, 450 U.S. 221, 232 (1981), the distinction here is "not between the mentally ill and a group composed of nonmentally ill," but rather between residents of IMDs and residents of other long-term care facilities. Such a distinction does not discriminate on the basis of handicap.

Finally, Connecticut ignores the fact that Congress has provided for the needs of the mentally ill between the

ages of 21 and 64 through the Community Mental Health Centers program.³¹ Indeed, it was this very program that the Long Amendment sought to encourage, rather than expanded reliance on Medicaid, when, as a condition of extending IMD coverage to the elderly, Congress required

³¹ The Community Mental Health Centers Act, enacted in 1963, Pub. L. No. 88-164, Tit. II, 77 Stat. 290 *et seq.*, authorized federal funding for the construction of community mental health centers (CMHCs). The House and Senate Reports on the Act emphasized that it was intended to promote alternatives to the custodial care traditionally provided in state mental institutions. See H.R. Rep. 694, 88th Cong., 1st Sess. 12 (1963); S. Rep. 180, 88th Cong., 1st Sess. 10 (1963). In 1965, Congress extended the time period for funding the construction of CMHCs and also for the first time authorized funds to be used to staff the centers. Pub. L. No. 89-105, 79 Stat. 427 *et seq.* Staffing grants were provided "on condition that the recipient community has a program providing at least the essential elements of comprehensive mental health services," including "[i]npatient services, outpatient services, emergency services, and consultation and education services." S. Rep. 366, 89th Cong., 1st Sess. 5, 6 (1965). The Act was extended by Congress on several subsequent occasions, and the list of required "essential services" was expanded. See 42 U.S.C. 2681 *et seq.* (repealed) codification note.

In 1980, Congress enacted the Mental Health Systems Act, Pub. L. No. 96-398, 94 Stat. 1564 *et seq.*, which again specified essential services that CMHCs were required to provide. This Act also provided grants for the care of chronically mentally ill individuals whose needs "have not been adequately met by the CMHC program." S. Rep. 96-712, 96th Cong., 2d Sess. 35 (1980).

In 1981, Congress repealed the Community Mental Health Centers Act and the Mental Health Systems Act and integrated both programs into a system of block grants to the states. Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, § 902, 95 Stat. 560, codified at 42 U.S.C. 300x *et seq.*, as amended by Pub. L. No. 98-509, 98 Stat. 2353. The new mental health services block grant program requires participating states to continue funding community mental health services, including services for the chronically mentally ill of all ages. 42 U.S.C. 300x-4(e). Unlike the earlier categorical grants under the Community Mental Health Centers Act and the Mental Health Systems Act, however, the block grant statute specifically prohibits states from spending federal funds on inpatient services for the mentally ill. 42 U.S.C. 300x-3(b) (1).

participating states to demonstrate satisfactory progress in developing and implementing comprehensive mental health programs. See page 4, *supra*. At the same time, however, Congress has been reluctant to appropriate the enormous amounts of money that might be required to make the CMHC program as comprehensive as the states would like. Initially, the CMHC program was intended to provide only "seed money" for the states to undertake construction of CMHCs. Although the program was later expanded to include funds for staffing and operating expenses (see note 31, *supra*), Congress has never funded the program as liberally as it has funded Medicaid. Moreover, Congress intentionally prohibited the states from continuing to use CMHC funds for inpatient services when it repealed the original statute and melded the program into a comprehensive block grant program. *Ibid.*

Congress's concern with cost has become even greater in recent years. The Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, 95 Stat. 357 *et seq.*, which made the CMHC program part of a health services block grant, was intended to reduce "by more than one-half [] the average annual growth in Federal spending in the past 5 years." S. Rep. 97-139, 97th Cong., 1st Sess. 2 (1981). The health services block grant was intended to facilitate a reduction of 20 to 25% in federal funding for the affected programs. See *id.* at 869. This concern was repeated in the 1984 amendments to the block grant program, when the Senate noted the "need to limit Federal spending at a time of large deficits." S. Rep. 98-381, 98th Cong., 2d Sess. 8 (1984).

In short, Connecticut asks this Court to interpret the IMD exclusion in a manner that would impose enormous costs on the federal government in the absence of any indication that Congress ever agreed to assume such costs and in the face of recent evidence that it instead acted intentionally to reduce federal spending for the care of the mentally ill between the ages of 21 and 64. If the states are unhappy with the level of federal spending for mental health care, their remedy lies with Congress, and not with the courts.

2. Connecticut's argument that HHS has in some way changed its interpretation of the IMD exclusion is completely unfounded. As previously noted (see page 6, *supra*), the agency made clear in the 1966 HPA, immediately after the Medicaid program was first enacted, that the focus of the IMD exclusion was on the "overall character" of a facility as one "established and maintained primarily for the care and treatment of individuals with mental diseases" (HPA ¶ D-4620.2). Subsequent regulations have repeated the same definition. See pages 7-8, *supra*. Such a long-standing administrative interpretation, based on a contemporaneous construction of a statute by those "charged with the responsibility of setting its machinery in motion, of making the parts work efficiently and smoothly while they are yet untried and new," is entitled to the greatest deference. *Aluminum Co. of America v. Central Lincoln People's Utility Dist.*, No. 82-1071 (June 5, 1984), slip op. 8 (citations omitted).

The only basis for Connecticut's contrary argument is the portion of the 1966 HPA that defined an IMD as an institution meeting the requirements of a psychiatric hospital as set forth in the Social Security Act (see note 6, *supra*). But that portion of the HPA in no way undermines the general focus on the "overall character" of a facility because, in 1966, ICF services were not even covered under the Social Security Act, skilled nursing facilities specializing in the care and treatment of the mentally ill were few and far between, and the HPA definition of SNF services itself precluded Medicaid coverage for the care and treatment of inpatients with mental diseases. HPA ¶ D-5141.4 provided as follows (emphasis added):

*Skilled Nursing Home Services (Other Than Services in an Institution for * * * Mental Diseases) for Individuals 21 Years of Age or Older*

This term is defined as those items and services furnished by a skilled nursing home maintained primarily for the care and treatment of inpatients with disorders other than * * * mental diseases which are

provided under the direction of a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by State law.

Notwithstanding the 1966 HPA's definition of an IMD as a psychiatric hospital, therefore, it is clear from other provisions of the HPA (and subsequent regulations) that the agency always has looked to the overall character of an institution. That the agency has not wavered from its interpretation is demonstrated by the fact that, as SNFs and ICFs specializing in the care and treatment of the mentally ill became increasingly common, the agency's regulations were amended to delete the provision defining an IMD as a psychiatric hospital. Compare 45 C.F.R. 249.10(b)(14)(iv) (1973) with 45 C.F.R. 249.10(b)(14)(iv) (1974). Accordingly, the agency's consistent and contemporaneous interpretation of the IMD exclusion should be upheld by this Court.

D. The Facts Of This Case Demonstrate Why Congress Could Not Have Intended To Limit IMDs To Traditional Mental Hospitals

1. The facts of this case well illustrate the illogic in Connecticut's position that only a mental hospital can be an IMD. The factual findings of the audit team, set forth at pages 11-13, *supra*, lead to one inescapable conclusion: "That which looks like a duck, walks like a duck, and quacks like a duck will be treated as a duck even though some would insist upon calling it a chicken." *Tidelands Marine Service v. Patterson*, 719 F.2d 126, 128 n.3 (5th Cir. 1983). In other words, there can be no doubt that Middletown Haven, even though certified as an ICF, was "primarily engaged in providing diagnosis, treatment or care of persons with mental diseases." 42 C.F.R. 435.1009 (e).

Connecticut does not dispute the findings of the audit team but nevertheless contends that the applicability of the IMD exclusion turns on the formal label applied to a facility, regardless of its factual characteristics.³² Such a

³² Although Connecticut does not dispute the audit team's findings, it does contend that the guidelines used by the reviewers

mechanistic approach would completely frustrate Congress's decision *not* to provide Medicaid coverage in IMDs for the mentally ill between the ages of 21 and 64. Connecticut has utterly failed to demonstrate that Congress has abandoned its long-held view that the care and treatment of such persons is a state responsibility, yet Connecticut's position would allow states to transfer a large portion of the responsibility for those very persons to the federal government.

A brief review of the criteria used by the Secretary to identify IMDs (see page 9, *supra*) demonstrates the unworkability of placing IMDs and ICFs into watertight compartments. While varying widely in relative importance, all ten criteria are rationally related to identifying IMDs; indeed, the relevance of the majority of the criteria is self-evident. For example, the medical profile of a facility's patients is of obvious importance in determining the "overall character" of the institution. The audit team found that an overwhelming number (77%) of the patients at Middletown Haven had diagnoses of mental diseases (J.A. 17a). Similarly, the staffing patterns (psychiatrists and non-medical personnel specially trained to care for the mentally ill (J.A. 22a-23a)), the heavy use of psychotropic drugs (J.A. 23a), and the staff's own perception that Middletown Haven is a psychiatric facility (J.A. 14a) are obviously relevant in determining the "overall character" of an institution.

The number of patients admitted to an ICF from state mental hospitals also is important, particularly where, as in this case, the record shows that large numbers of those patients either were returned to the mental institution from which they had come or transferred to other institutional settings. Very few were returned to community living, thus strongly supporting the finding that Middle-

were "nonspecific criteria of doubtful validity" (Br. 94 (footnote omitted)). But the "validity" of the guidelines is not before the Court; the only question presented is whether, as a matter of statutory construction, an ICF can ever be an IMD. See Pet. i; see also page 48, *infra*.

town Haven was used as a facility for persons who actually required care and treatment in a mental institution. See J.A. 17a-18a. Similarly, another criterion, age distribution uncharacteristic of nursing home patients (a preponderance of patients under age 65), is significant because nursing home residents with physical ailments tend as a group to be older than patients with mental disabilities. See J.A. 20a. The relevance of the institution's license to care for individuals with psychiatric conditions is clear (J.A. 13a-14a).

All of these factors clearly support the audit team's ultimate determination that Middletown Haven "is primarily engaged in providing psychiatric services to residents with a mental illness" (J.A. 24a). Common sense compels the conclusion that such a facility must be classified as an IMD.

2. Every other court that has considered the meaning of the IMD exclusion has rejected the notion that ICFs can never be IMDs. Connecticut's contrary contention (Br. 4) is simply erroneous.³³ It is true that the courts that have considered the matter have reached varying results, but not on the sole issue that is before this Court—whether the IMD exclusion is limited to traditional mental hospitals.

For example, Connecticut erroneously contends (Br. 82 n.62) that the Eighth Circuit held in *Minnesota v.*

³³ Nor is the decision in *Schweiker v. Wilson*, 450 U.S. 221 (1981), of any assistance to Connecticut. In *Wilson*, the Court did not rule that IMDs and ICFs are mutually exclusive categories of institutions. Indeed, the Court did not even address the issue of the definition of the term "institution for mental diseases." Instead, the Court addressed the constitutionality, under equal protection principles, of a statute excluding from Supplemental Security Income benefits those residents of public mental institutions who are subject to the IMD exclusion. Connecticut therefore errs in relying (Br. 80-81) on references in both the majority and dissenting opinions in *Wilson* to selected portions of the legislative history of the IMD exclusion, because that history merely confirms that a state mental hospital is an IMD—a fact clearly not at issue here and certainly not inconsistent with the notion that an ICF also can be an IMD.

Heckler, 718 F.2d 852 (1983), that ICFs and IMDs are mutually exclusive. In fact, the Eighth Circuit clearly recognized that IMDs may encompass a broad range of care and treatment (718 F.2d at 866; Pet. App. 23e):

IMD treatment may * * * include a higher degree of care and treatment than is provided by facilities which only offer SNF or ICF services. However, based on legislative history, it may also include custodial 'room and board' care which is not aimed at simultaneously providing active or therapeutic treatment leading to cure.

This statement would have been totally unnecessary had the Eighth Circuit thought that IMDs and ICFs were mutually exclusive types of facilities.³⁴

Moreover, the decision of the United States District Court for the District of Minnesota that the Eighth Circuit affirmed also ruled that an IMD can be a facility other than a mental hospital. *Minnesota v. Schweiker*, No. 4-82-155 (Aug. 25, 1982). The district court concluded that "[t]here is no inherent logic to the position that an institution for mental diseases can only be a mental hospital." Slip op. 9. The district court further held that if "an institution provided solely psychiatric services at a SNF level of care to 100% of its patients, it would be an IMD. Similarly, the State cannot relocate mentally ill persons from one institution to a number of smaller institutions and provide approximately the same care and hope to avoid the operation of the IMD exclusion." Slip op. 14 (emphasis added).

The district court in the instant case also recognized that an ICF can be classified as an IMD. See Pet. App. 5c, 7c. Furthermore, the district court defined an IMD

³⁴ Connecticut has argued that the Secretary's reliance on this passage is misplaced. Connecticut contends (Reply Br. 2 n.2) that the Eighth Circuit meant only that a facility could be classified as an IMD if its residents required the *intensive* level of psychiatric or custodial care characteristic of mental hospitals. But nowhere did the Eighth Circuit state that IMD care is in all cases more "intensive" than ICF care; on the contrary, the passage quoted above clearly suggests the opposite conclusion.

as including the care given to "a nursing home resident" (*id.* at 7c n.9), even though Connecticut contends that ICFs and SNFs can never be IMDs.³⁵ Finally, the United States District Court for the Northern District of Illinois expressly stated that it was not "hold[ing]" that the categories of IMD and ICF are mutually exclusive." *Illinois v. United States Dep't of Health and Human Services*, No. 82-C-1349 (Mar. 20, 1984), slip op. 3 n.1, appeal pending, No. 84-2615 (7th Cir.); Pet. App. 3f n.1.³⁶

³⁵ Inexplicably, however, the district court proceeded to reject its own statutory analysis in favor of its self-created "total care" concept (see note 11, *supra*).

³⁶ To be sure, as Connecticut points out (Br. 101), the decisions cited above differ to some extent from the decision of the court of appeals in this case. But the differences stem from the courts' differing evaluations of the supplemental criteria used by the Secretary to determine whether an institution (including an ICF) warrants classification as an IMD—an issue not before this Court. Moreover, even as to the criteria, the differences are more semantic than real. For example, the court below stated that "the IMD exclusion virtually compels HHS to focus on the nature of the illness treated rather than the care furnished" (Pet. App. 16a), whereas the Eighth Circuit stated that "the characterization of an IMD must fundamentally center on the type of care or nature of services *required*, not on the mere presence in a facility of patients who have, or at one time did have, diagnoses of a mental disease" (718 F.2d at 863; Pet. App. 17a (emphasis added)). As a practical matter, however, the Eighth Circuit's focus on "care and treatment" does not constitute a significant departure from the Second Circuit's focus on diagnoses. Thus, in most, if not all, cases (including this one), ICFs that qualify as IMDs under the Second Circuit's approach because they contain large numbers of patients who suffer from mental diseases also will be found to be IMDs under the Eighth Circuit's approach because extensive mental health care and treatment would be required in such facilities.

In any event, most of the ten criteria that the Secretary uses to supplement her regulation in making the determination whether the overall character of an institution warrants treatment as an IMD do not focus on diagnoses. See page 9, *supra*. We note in this regard that the psychiatrist who led the audit team at Middletown Haven gave testimony before the Departmental Grant Appeals Board concerning the types of mental health services provided at

II. THE DISALLOWANCE AT ISSUE DOES NOT CONTRAVENE THE CONCEPTS OF "FEDERALISM" THAT UNDERLIE THE MEDICAID PROGRAM

A. Connecticut's "Federalism" Argument Is Not Properly Before The Court

Contending that the states lacked meaningful advance notice of HHS's interpretation of the IMD exclusion, Connecticut argues that the disallowance of federal funds in the instant action "undermines the federalism concept on which the public assistance programs are based" (Br. 93). This issue is not properly before the Court because it is not even remotely subsumed within the question presented in Connecticut's petition for a writ of certiorari (see Pet. i, 4).³⁷ See, e.g., *Irvine v. California*, 347 U.S. 128, 129 (1954) (disapproving of the practice of "smuggling additional questions into a case after [the Court] grant[s] certiorari").

Nor can it be contended that Connecticut's new argument simply advances policy reasons in support of its position that IMDs and ICFs are mutually exclusive. On the contrary, Connecticut's "federalism" argument, if accepted by this Court, could result in a reversal of the disallowance for Middletown Haven even if the Court were to agree with the court of appeals on the question actually presented. Thus, the "federalism" issue is not fairly subsumed within the question presented, and it should not be considered by this Court.

Middletown Haven in support of his conclusion that the facility was an IMD. See J.A. 20c-21c; 24c-25c; C.A. App. 79-81, 91. The determination that Middletown Haven was an IMD therefore did not depend solely on the diagnoses of the patients.

³⁷ Moreover, the court of appeals did not address the issue. This is not surprising because Connecticut did not identify the issue as a question presented, and its brief (at 36-37) contained only a passing citation to *Pennhurst State School & Hospital v. Halderman*, 451 U.S. 1 (1981). This was hardly sufficient to bring the issue to the lower court's attention.

B. Connecticut's "Federalism" Argument Is Erroneous In Light Of The Statute And The Record In This Case

1. Even if Connecticut's "federalism" argument were properly before the Court, it is erroneous. Connecticut first maintains (Br. 93-102) that the disallowance at issue was based on new and uncertain policies not implemented until after the federal funds were received and spent. But Connecticut provides its own rebuttal to this argument. Connecticut candidly admits that it "became aware of the issue of the extension of the IMD exception to SNFs and ICFs in 1976" (Br. 95 n.74 (emphasis added)). Even if one were to assume (which we do not) that the IMD exclusion was *extended* to SNFs and ICFs in 1976, the Secretary's interpretation existed before the 1977-1979 period at issue in this case and Connecticut knew it. Moreover, even if Connecticut did not have notice of all of the criteria used to determine whether a facility was an IMD (see page 9, *supra*), those criteria were mere guidelines that focused audit teams on the factors to be considered in determining whether the "overall character" of an institution established that it was an IMD. See Pet. App. 30d-31d. Thus, the criteria served to implement an IMD policy that has been clear and consistent since 1966. See pages 42-43, *supra*.

Furthermore, Connecticut has never challenged the Secretary's regulatory definition of IMDs (42 C.F.R. 435.1009(e)). That definition is without doubt broad enough to encompass ICFs and SNFs. Thus, there is no merit to Connecticut's contention (Br. 98-99 & n.78) that the regulation did not give "meaningful notice" that an ICF or SNF could be classified as an IMD, especially in view of Connecticut's concession (Br. 95 n.74) that it knew of HHS's policy in 1976.

2. Connecticut's argument apparently is also based on the fact that, even though HHS knew that Middletown Haven had been certified by the State as an ICF, the agency did not disallow payments immediately. But this demonstrates no more than the fact that Middletown

Haven can be an ICF and, depending on its other characteristics, an IMD as well. It was for the purpose of making the IMD determination that the audit involved here was conducted.

In conducting the audit and determining that the challenged disallowance was required, HHS did not alter its position as to the facility in question. Rather, the agency followed the reimbursement procedure required by statute, pursuant to which states participating in the Medicaid program are advanced funds prior to the quarters for which they are to be expended based on the states' estimate of reimbursable expenditures. 42 U.S.C. 1396b(d)(1). Only after expenditures were actually incurred by Connecticut could HHS have undertaken the audit it conducted in this case to determine whether those expenditures were, in fact, reimbursable. Adjustments based on such audits are not only contemplated but are required by statute; 42 U.S.C. 1396b(d)(5) states unequivocally that the "Secretary shall offset [the overpayment or disallowance] from any subsequent payments made to [the] State under this subchapter" (emphasis added).

The certification of Middletown Haven as an ICF was an action taken solely by Connecticut; that certification did not (and could not) bind the Secretary on the question whether Middletown Haven also should be classified as an IMD. When Middletown Haven was audited and was determined to be ineligible for reimbursement because it was an IMD, the Act required recoupment. A ruling such as Connecticut requests would prevent an agency from recovering grant funds that, after audit, are discovered to have been improperly paid. Such a result is clearly inappropriate and contrary to the Act itself. See *Bell v. New Jersey*, 461 U.S. 773, 780-783 (1983).²⁸

²⁸ Connecticut's reliance (Br. 103-108) on *Pennhurst State School & Hospital v. Halderman*, 451 U.S. 1 (1981), is misplaced for the reasons explained in our brief in *Sec'y of Education v. Kentucky*, No. 83-1798 (argued Jan. 8, 1985). We are furnishing a copy of that brief to petitioner's counsel. We note also that the correct disposition of the instant case does not depend in any way

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted.

REX E. LEE

Solicitor General

RICHARD K. WILLARD

Acting Assistant Attorney General

KENNETH S. GELLER

Deputy Solicitor General

KATHRYN A. OBERLY

Assistant to the Solicitor General

ROBERT S. GREENSPAN

HOWARD S. SCHER

Attorneys

FEBRUARY 1985

upon the Court's decision in *Sec'y of Education v. Kentucky*, *supra*. In light of Connecticut's admission that it knew of the Secretary's IMD policy at least since 1976, there can be no claim that its subsequent, erroneous interpretation of that policy was "reasonable."

APPENDIX A

Relevant provisions of the Medicaid statute, Title XIX of the Social Security Act, 42 U.S.C. 1396 *et seq.*, as further amended by the Medicare and Medicaid Budget Reconciliation Amendments of 1984, Pub. L. No. 98-369, 98 Stat. 1061 *et seq.*, are as follows:

1. Section 1905(a) of the Social Security Act, 42 U.S.C. 1396d(a), as further amended by the Medicare and Medicaid Budget Reconciliation Amendments of 1984, Pub. L. No. 98-369, § 2335(f), 98 Stat. 1091, provides in pertinent part:

Medical Assistance

The term "medical assistance" means payment of part or all of the cost of the following care and services * * * for individuals * * *

(1) inpatient hospital services (other than services in an institution for mental diseases);

* * *

(4)(A) skilled nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older;
* * *

* * *

(14) inpatient hospital services, skilled nursing facility services, and intermediate care facility services for individuals 65 years of age or over in an institution for mental diseases;

(15) intermediate care facility services (other than such services in an institution for mental diseases) for individuals who are determined * * * to be in need of such care;

(16) effective January 1, 1973, inpatient psychiatric hospital services for individuals under age 21 * * *;

* * *

(1a)

except as otherwise provided in paragraph (16), such term does not include * * (B) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases.

2. Section 1905(c) of the Social Security Act, 42 U.S.C. 1396d(c), provides in pertinent part:

For purposes of this subchapter the term "intermediate care facility" means an institution which (1) is licensed under State law to provide, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities * * *. The term "intermediate care facility" also includes any skilled nursing facility or hospital which meets the requirements of the proceeding [sic] sentence. * * * With respect to services furnished to individuals under age 65, the term "intermediate care facility" shall not include, except as provided in subsection (d) of this section, any public institution or distinct part thereof for mental diseases or mental defects.

APPENDIX B

Set forth below is a table summarizing the differences between the traditional mental hospital of the 1950s and the typical, progressive mental hospital of the 1970s. The table appears in H. Gottesfeld, *Alternatives to Psychiatric Hospitalization* 34 (1977).

CHANGES IN MENTAL HOSPITALS

<i>Typical Mental Hospital 1950s</i>	<i>Typical, Progressive Mental Hospital, 1970s</i>
1. Large inpatient population	1. Smaller inpatient population.
2. Long term stay	2. Short term stay
3. Many physical restraints (barred windows, locked wards, camisoles)	3. Few physical restraints
4. Authoritarian planning. Plans and decisions are made by hospital and clinical administrators.	4. More democratic planning. Patients and staff have say in certain activities and decisions.
5. Enforced, routine schedule. All patients do same activities at same time.	5. A variety of programs and individualized treatments suited to patient's needs. Some programs are voluntary.
6. Discipline arbitrary, sometimes brutal. Beatings are not rare.	6. Formal hearing required for disciplinary action. Beatings rare, often followed by an investigation.
7. Psychosurgery and electroconvulsive therapy (ECT) common treatment modalities.	7. Psychosurgery, rare; electroconvulsive therapy rarely utilized with patients other than extremely depressed patients. Both treatments require informed consent and are subject to professional review.
8. Patients exploited doing menial work for hospital. Patients may receive hospital "privileges" for work.	8. Patients paid for hospital work. Hospital often has community employment or work training.

4a

- | | |
|---|--|
| <p>9. Personal possessions discouraged. Patients issued hospital clothing and supplies for their needs. Patients not allowed to keep money on ward.</p> <p>10. Little privacy. Patient observed closely on ward. Visits by others are supervised, mail opened and censored, use of telephone requires permission.</p> | <p>9. Personal possession encouraged. Patient keeps his own clothes, money, other items.</p> <p>10. Much more privacy. Patient may have private or semi-private room. There is a private visiting area, no censorship of mail and access to telephone is unrestricted.</p> |
|---|--|

10
No. 83-2136

Office - Supreme Court, U.S.
FILED
MAR 6 1985
ALEXANDER L. STEVAG
CLERK

IN THE
Supreme Court of the United States
OCTOBER TERM, 1984

STATE OF CONNECTICUT,
DEPARTMENT OF INCOME MAINTENANCE,
Petitioner,

v.

MARGARET M. HECKLER, SECRETARY,
AND THE UNITED STATES DEPARTMENT
OF HEALTH AND HUMAN SERVICES,
Respondents.

On Writ Of Certiorari To
The United States Court Of Appeals
For The Second Circuit

REPLY BRIEF FOR PETITIONER

JOSEPH I. LIEBERMAN
Attorney General
30 Trinity Street
Hartford, Connecticut 06106

DONALD M. LONGLEY
Assistant Attorney General
90 Brainard Road
Hartford, Connecticut 06114

CHARLES A. MILLER
MICHAEL A. ROTH
ROBIN J. ARMBRUSTER
COVINGTON & BURLING
1201 Pennsylvania Ave., N.W.
P.O. Box 7566
Washington, D.C. 20044
(202) 662-6000

*Attorneys for Petitioner State
of Connecticut, Department of
Income Maintenance*

*Counsel of Record
March 1985

394

TABLE OF CONTENTS

	<u>Page</u>
I. RESPONDENTS' ERRONEOUS APPROACH TO THIS CASE.	2
A. The Incorrect Premise That Congress Adopted a "Blanket Prohibition" on Federal Support for Care of the Mentally Ill.	2
B. The Erroneous Refusal To Accept the Facility-Based Distinction Adopted By Congress.	7
C. The Unsupported Efforts To Narrow the Unconditional ICF Definition.	12
II. FISCAL IMPLICATIONS OF THE OUTCOME OF THIS CASE.	14
III. RESPONDENTS' INCORRECT STATUTORY ANALYSIS.	15
A. The Terms of the Medicaid Statute.	16
B. Legislative History -- The Long Amendment and Later Proposals	20

	<u>Page</u>
C. The Unaltered Department Regulations	25
D. Community Mental Health Center Legislation.	28
IV. THE PROPRIETY OF THE "PENNHURST" ARGUMENT.	29
CONCLUSION	31

TABLE OF AUTHORITIES

	<u>Page</u>
<u>CASES</u>	
<u>Califano v. Yamaski</u> , 442 U.S. 682 (1979).	30
<u>ICC v. Railway Labor Executives Association</u> , 315 U.S. 373 (1942)	23
<u>Pennhurst State School v. Halderman</u> , 451 U.S. 1 (1981).	29-30
<u>St. Martin Evangelical Lutheran Church v. South Dakota</u> , 451 U.S. 772 (1981)	30
<u>Schweiker v. Wilson</u> , 450 U.S. 221 (1981)	10
<u>United States v. Guerlain</u> , 155 F. Supp. 77 (S.D.N.Y. 1957)	24
<u>STATUTES</u>	
Adoption Assistance and Child Welfare Act of 1980, Pub. L. No. 96-272, 94 Stat. 530 § 306	15

	<u>Page</u>
Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, Pub. L. No. 88-164, 77 Stat. 282	28
Social Security Act of 1935, 49 Stat. 620	
Title I	4
Title IV	4-5
Title X	4-5
Social Security Act Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1459-60 § 297	17
42 U.S.C. § 1395x(j)	16
42 U.S.C. § 1396a(a)(28)	16
42 U.S.C. § 1396d(a)	16
42 U.S.C. § 1396d(c)	12

LEGISLATIVE MATERIALS

Reports

H.R. Rep. No. 615, 74th Cong., 1st Sess. (1935)	6
--	---

	<u>Page</u>
H.R. Rep. No. 1605, 92d Cong., 2d Sess. (1972)	18
S. Rep. No. 1230, 92d Cong., 2d Sess. (1972)	18

Hearings and Debates

Social Security Amendments of 1970: Hearings Before the Senate Committee on Finance on H.R. 17550, 91st Cong., 2d Sess. (1970)	25
118 Cong. Rec. 36914, 36936 (1972)	18

ADMINISTRATIVE MATERIALS

42 C.F.R. § 405.1035 (1983) . . .	27
42 C.F.R. § 405.1036 (1983) . . .	27
42 C.F.R. § 405.1037 (1983) . . .	27
42 C.F.R. § 405.1038 (1983) . . .	27
42 C.F.R. § 440.140(a)(1)(ii) (1983)	27

	<u>Page</u>
42 C.F.R. Part 442, Subparts D, E, and F (1983).	22
42 C.F.R. § 442.12 (1983)	15
42 C.F.R. § 233.90 (1984).	5
Department of Health, Education and Welfare, Social Security Administration, Office of Research and Statistics: Financing Mental Health Care Under Medicare and Medicaid (Research Report No. 37) (1971).	27

No. 83-2136

IN THE
SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1984

STATE OF CONNECTICUT,
DEPARTMENT OF INCOME MAINTENANCE,

Petitioner,

v.

MARGARET M. HECKLER, SECRETARY,
AND THE UNITED STATES DEPARTMENT
OF HEALTH AND HUMAN SERVICES,

Respondents.

ON WRIT OF CERTIORARI TO
THE UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

REPLY BRIEF FOR PETITIONER

Respondents have put forward a flawed
analysis of the Social Security Act

provisions in question in this case. Connecticut submits this reply brief to show the deficiencies in the respondents' argument and how they confirm the correctness of the State's position.

I. RESPONDENTS' ERRONEOUS
APPROACH TO THIS CASE

A. The Incorrect Premise That
Congress Adopted a "Blanket
Prohibition" on Federal
Support for Care of the
Mentally Ill

Respondents repeat the error of the court below by resting their case on the premise that Congress made a conscious judgment when the Social Security Act was initially adopted not to undertake financial support for any care of the mentally ill under the public assistance titles, choosing instead to leave this "fiscal responsibility" with the states. Resp. Br. 15. Respondents broadly define that antecedent bar as a "blanket prohibition against funding for the mentally ill"

(ibid.), and they reiterate the "blanket" nature of the supposed ban. Id. at 15, 16, 25; also at 44. They then proceed to refer to certain respects in which the Social Security Act was subsequently modified to embrace care of the mentally ill in specifically defined circumstances, find no such change for under-65 year-old residents of ICFs specializing in care of the mentally ill, and conclude that the perceived antecedent bar defeats claims for federal funds in such circumstances. Id. at 15-17.¹

The trouble is that respondents' premise is plainly wrong. There has never been a "blanket prohibition against funding for the mentally ill," and respondents

¹ Respondents seek to bolster their position by asserting that "Congress has never taken any affirmative action to provide blanket Medicaid coverage for the treatment of [the] mental conditions" of the mentally ill between the ages of 21 and 64. Resp. Br. 16.

cannot, and do not, cite anything (other than the IMD clause itself, the very provision whose meaning this case seeks to determine) in support of any such "blanket" determination.

Far from imposing any "blanket" prohibition, Congress from the beginning has included the mentally ill among those to be covered by Social Security Act public assistance programs. The initial program of aid to the aged contained in the 1935 Act (Title I) extended to any needy person aged 65 or over, whether or not mentally ill. The only exception was for persons in public institutions of any kind. Thus, for example, elderly mentally ill people residing in private institutions, as well as those not institutionalized, were eligible for coverage under the initial law. Titles IV (Aid to Dependent Children) and X (Aid to the Blind) similarly extended

to all who qualified, whether or not they were mentally ill.

Likewise, when the Act was amended in 1950 to provide assistance to the disabled, those with mental impairments as well as those with physical impairments were covered. See 45 C.F.R. § 233.90 (1984). At the same time, the Title I program of aid to the aged was modified to embrace medical expenses, and enlarged to permit coverage of persons in public medical institutions. In connection with these new or expanded programs, Congress adopted an exception for patients in IMDs, and in medical hospitals with psychosis or tuberculosis diagnoses.² This was avowedly an exception, applicable to residents of certain facilities, from

² The exception also applied to residents of tuberculosis institutions.

general coverage for the mentally ill that met the eligibility requirements of the programs, and did not represent any "blanket" prohibition on coverage of the mentally ill, who as a class had been included from the beginning in the beneficial assistance programs of the Act.³ Thus, the meaning and scope of the IMD clause cannot be resolved by reference to a supposed "blanket prohibition" on funding for the mentally ill; respondents' faulty reliance on this non-existent prohibition cannot substitute for analysis of the IMD clause itself.

³ Respondents repeatedly refer to the states' "long-standing responsibility for the care of the mentally ill." Resp. Br. 28; also 15, 44. But apart from those residing in state mental hospitals, the needy mentally ill were no more the responsibility of states than were other needy citizens embraced within the public assistance titles, all of whom states had sought to aid to the extent of their abilities. See H.R. Rep. No. 615, 74th Cong., 1st Sess. 4, 10 (1935).

B. The Erroneous Refusal To Accept the Facility-Based Distinction Adopted By Congress

Since the task of interpreting the IMD clause in the Medicaid law cannot be avoided by assuming the result, as respondents seek to do, there must be an objective assessment of what Congress meant when it adopted that exception to its general coverage provisions. Such an assessment reveals, as shown in petitioner's opening brief, that the exception was motivated by an aversion to supporting mental hospitals. That judgment was based on a century of experience with state mental hospitals, and was confirmed by the seminal Congressionally-commissioned five-year study of mental health in America, which emphasized how outmoded these institutions had become.

Respondents ignore all of this history in their brief. Instead, they disparagingly

characterize the distinction based on the nature of the institutional setting as "artificial" and "single-minded," and argue that coverage should turn on the nature of the patients involved. Resp. Br. 27. Though respondents would belittle a coverage test based on the type of facility in which a person resides, this is the distinction that Congress made, and respondents ultimately so acknowledge when they say that "the statute merely limits the types of facilities in which [the mentally ill] may receive covered services." Id. at 39.*

* This statement is also at odds with respondents' earlier argument (Resp. Br. 15-16) to the effect that there was a "blanket prohibition" on funding services "for any category of the mentally ill."

Respondents say the facility-oriented distinction creates "financial disincentives" to the improvement of state mental hospitals. Resp. Br. 26-27. But Congress considered this issue, and concluded that the Long Amendment, which offered federal support for mental hospitals for people over 65 if a number of programmatic conditions were satisfied, would afford ample incentive for improvement. Whatever changes have taken place in mental hospital characteristics along the lines emphasized in respondents' brief (pages 35-36) occurred during the time the states were claiming and receiving federal support for ICFs that respondents now seek to classify as IMDs, thus confirming both the success of the Congressional initiative

and the hollowness of respondents' argument.⁵

Respondents criticize petitioner's interpretation because it distinguishes between free-standing ICFs (which are not IMDs) and hospital-based ICFs (which can be). Resp. Br. 27. Respondents simply assert that the services offered by the two types of facilities are "identical." Yet the Congressional exception rests on the contrary premise -- that state mental hospital characteristics were unique. This was surely a valid judgment for

⁵ Respondents also advance a *reductio ad absurdum* to the effect that Connecticut's approach would preclude federal funding for a mental hospital even if it were to give itself over entirely to providing ICF or SNF levels of care. Resp. Br. 27. There is no evidence that such a transformation of any state mental hospital has occurred, so that this theoretical logical conundrum does not detract from the Congressional judgment that mental hospitals as a group deserved different treatment than other institutional facilities, in light of their unique characteristics. Cf. *Schweiker v. Wilson*, 450 U.S. 221 (1981).

Congress to make, given the well-documented history of that singular phenomenon.⁶

Finally, respondents' approach produces the truly arbitrary result that a mentally ill person can qualify for Medicaid while being treated in a general hospital yet lose eligibility when transferred to a nursing home that specializes in the care of the mentally ill. See Resp. Br. 39.

⁶ Respondents evidence a true failure to grasp the distinctions made by Congress when they seek to equate service provided to the mentally ill in a mental hospital and in an ICF (Resp. Br. 43), even though there are significant differences in the levels of care provided in the two categories of facilities. See Pet. Br. 51, n.38, 115-116, n.88. That is why respondents' duck-chicken analogy is inapt. The more pertinent analogy, apropos of respondents' arguments, is to the ostrich.

C. The Unsupported Efforts To
Narrow the Unconditional ICF
Definition

In the end, despite aggressive advocacy,⁷ respondents cannot avoid the specific statutory provision that defines an ICF qualifying for federal support as an institution caring for those requiring the specified level of care because of their physical or mental condition. 42 U.S.C. § 1396d(c). They present the question as whether this unconditional provision "supersedes the blanket IMD provision" (Resp. Br. 25); but as has been shown, there is no basis for the "blanket" sobriquet. Respondents' further efforts to explain away the ICF definition

⁷ See, for example, Resp. Br. 24 ("In the absence of any statutory provision that supports [Connecticut's] position"); id. at 23 ("Connecticut does not point to a single section of the Medicaid statute that refutes the plain meaning of the sections described above").

are as weakly stated and as unpersuasive as were the similar efforts of the court below. They say the provision is "susceptible to an interpretation" consistent with the Secretary's reading, because the reference to persons with mental conditions "most probably" refers to aged patients with mental illness, or "also may apply" to the mentally retarded. Resp. Br. 25-26. These tentative assertions depend upon reading into the statute qualifying words that are not there. Nor were the qualifications intended. From the time that ICFs were first brought into the Act in 1967, Congress meant them to provide for persons with physical or mental conditions, without qualifications, because there was a perceived need for the type of service that ICFs provide for such needy persons. Pet. Br. 46-47.

II. FISCAL IMPLICATIONS OF THE OUTCOME OF THIS CASE

Respondents refer to the "staggering" impact of acceptance of Connecticut's position in this case. Resp. Br. 17. That is a red herring. The real staggering impact would be on the states if the federal position were to prevail, for states would have to raise and return to the federal government tens if not hundreds of millions of dollars in funds long since received and expended in the care of needy nursing home residents. On the other hand, if respondents prevail, the federal government will enjoy an unexpected return from the many states that have drawn Medicaid funds over the past decade to help finance the care of persons in nursing homes that may now be found to be IMDs. There is certainly no basis for any claim of dire impact on the

federal fisc should the State's position prevail here."

III. RESPONDENTS' INCORRECT STATUTORY ANALYSIS

Respondents argue that their position is supported by statutory wording, legislative history and regulations. They are incorrect in all three instances.

* To the extent states have continued to receive federal funds for facilities that may be determined to be IMDs, there is obviously no additional exposure beyond what the federal government has paid for as long as the facilities have been participating in the program. To the extent (if at all) that states have failed to certify facilities for program participation because of the concern that they might be classified as IMDs, there can be no claim for federal participation, for certification is a condition precedent to participation. 42 C.F.R. § 442.12 (1983).

There could be facilities that are certified but for which states have suspended claims for federal funding, at least pending the outcome of this case. But even if such situations exist, the federal exposure is limited because of the provision, enacted in 1980, barring payment of any claim for federal financial participation not filed within two years of the expenditure by the state. Pub. L. No. 96-272, § 306, 94 Stat. 530 (1980).

A. The Terms of the Medicaid Statute

As anticipated, respondents rely primarily on the section of the statute listing covered Medicaid services (42 U.S.C. § 1396d(a)), particularly subsection (15). Subsection (15) refers to ICF services other than such services in an IMD.⁹ Petitioner's opening brief showed that the IMD phrase in this subsection referred to ICF-type services provided in mental hospitals, and cited the pertinent legislative history showing that the addition of this phrase was meant to assure that

⁹ See also subsection (14) which also speaks of ICF services. Likewise, the definition from the Handbook of Public Assistance in 1966 on which respondents rely (Resp. Br. 42) is of "Skilled Nursing Home Services" (emphasis supplied).

The Medicaid provisions on skilled nursing facilities (42 U.S.C. § 1396a(a)(28)) adopt the Medicare definition for skilled nursing facility except for the exclusion for institutions which are primarily for the care and treatment of mental diseases. These institutions are embraced within the Medicaid program. Cf. 42 U.S.C. § 1395x(j).

such services in mental hospitals, though permitted, were not mandatory (even though coverage of hospital services generally was mandatory). Pet. Br. 67-68.¹⁰

This meaning was confirmed specifically as to ICFs in 1972. When ICFs were brought under the Medicaid program in 1971, there was an inadvertent failure to amend subsection (15) of the list of covered services, which theretofore had listed inpatient hospital and skilled nursing facility services for persons aged 65 and over in IMDs as covered services. The omission was corrected by a technical amendment in 1972,¹¹ originating in the Senate Finance Committee, which described the change as clarifying that

¹⁰ Respondents do not mention the latter evidence.

¹¹ Social Security Act Amendments of 1972, Pub. L. No. 92-603, § 297, 86 Stat. 1459-60 (1972).

ICF services are to be covered "for individuals 65 and over in mental institutions, as well as inpatient hospital services and skilled nursing home services." S. Rep. No. 1230, 92d Cong., 2d Sess. 321 (1972).¹²

¹² Respondents cite the conference report description of this technical provision as indicating that ICFs as well as SNFs and hospitals can be IMDs. Resp. Br. 31. But as the District Court so clearly demonstrated (Pet. App. 18c), the brief excerpt in the conference report was inaccurate. The conference report erroneously describes the technical amendment as requiring coverage of ICF services in IMDs if a state covers hospital and skilled nursing home services in IMDs. The amendment does not so provide, and has not been so construed by DHHS. The conference report mistakenly included its discussion of this amendment under a heading applicable only to Medicare provisions. These errors presumably occurred because of the end-of-session rush. The conference committee reached agreement on the 165-page bill and ordered printing of a conference report on Saturday, October 14, 1972. H. R. Rep. No. 1605, 92d Cong., 2d Sess. 1 (1972). The House and Senate each accepted the conference proposal on the following Tuesday, October 17, 1972, the day before Congress adjourned for the year. 118 Cong. Rec. 36914, 36936. It is apparent that the conference report summary of this technical change, which received no significant attention during the conference of

(footnote cont'd)

Respondents also find comfort in the 1972 change that extended Medicaid coverage to services provided in "psychiatric hospitals" for children, contending that the term "psychiatric hospital" would not have been used had the term IMD been recognized as applying only to mental hospitals. Resp. Br. 23. This argument fails because the 1972 amendment did not extend to all mental hospitals, but only to those that met a number of specific criteria included in the statute. Congress used the term "psychiatric hospital" to refer to those hospitals that satisfied the special criteria.

(footnote cont'd)

the two Houses, is not a reliable source for determining the meaning of the Medicaid provision at issue in this case.

B. Legislative History -- The
Long Amendment and Later
Proposals

An important element in Connecticut's case is the showing that the Long Amendment, adopted as part of the original Medicaid Act in 1965, sharply distinguished between IMDs, on the one hand, and alternatives, including nursing homes, on the other hand. See Pet. Br. 44-45, 51-52. Respondents attempt to brush aside the significance of this section of the law by arguing that the Long Amendment applies only to the elderly. Resp. Br. 18, 29, 32. Yet this response misses the point. Even if the Long Amendment provisions were confined to the elderly, they demonstrate that Congress understood and treated nursing homes (SNFs and later ICFs) as distinct from, and not a category within, IMDs. That is why the Long

Amendment so strongly supports the interpretation advanced by petitioner. Respondents fail to appreciate its significance because of their unwarranted premise that the IMD clause reflects an antecedent Congressional decision to exclude all coverage of the mentally ill. Yet the Long Amendment confirms what is already demonstrated by the history of the Act -- that the IMD clause itself was a confined exception to the principle that the public assistance provisions were available to all persons in the need categories without differentiation based on the nature of affliction.

In an effort to avoid the impact of the Long Amendment, respondents refer to articles critical of the care provided in some nursing or boarding facilities or "welfare hotels" and argue from them that Congress would not "have wanted Medicaid

funds to go to 'alternative' facilities that were no better than the traditional institutions they were replacing." Resp. Br. 38. Perhaps so. But not all boarding or nursing facilities qualify for Medicaid participation, and certainly "welfare hotels" do not. Department rules specify in elaborate detail the conditions of participation for ICFs and SNFs. They cover program requirements as well as physical environment, staffing, residential services, and safety conditions. See 42 C.F.R. Part 442, Subparts D, E, and F (1983). General references to poor care in some "alternative" facilities do not help resolve the issue presented here -- whether a facility that meets the

elaborate federal standards qualifies for Medicaid.¹³

Respondents adopt the error of the court below and attempt to rely on post hoc evidence of Congressional refusal to modify the IMD clause despite pleas that it do so in 1967, 1970 and 1972. Resp. Br. 18, 30, 31, 32. Evidence of what Congress later failed to do is a suspect method of construing what Congress actually did earlier. See ICC v. Railway Labor Executives Association, 315 U.S.

¹³ To the extent pertinent, respondents' articles undermine the DHHS position. One study is quoted as finding that "psychiatric disturbances are probably the predominant form of illness in nursing homes, and yet psychiatric care in these homes is generally deficient." Resp. Br. 38, n.29. Yet, respondents' position would deter correction of this perceived problem by denying federal support to the very homes trying to solve the problem by specializing in care for the mentally ill.

373, 378-80 (1942).¹⁴ "If the failure of enactment of every amendment offered for the consideration of Congress were necessarily held to shed light on the legislation sought to be amended, the search for Congressional intention would be endless and fruitless." United States v. Guerlain, Inc., 155 F. Supp. 77, 82 (S.D.N.Y. 1957).

Here, there is an even greater flaw. The proposals that were not accepted did not relate to the issue now before the Court. The proponents of change were seeking full Medicaid coverage for mental hospitals, as the quoted excerpts in respondents' brief suggest

¹⁴ In that case, the Court said that a conclusion that Congress' failure to amend certain statutory provisions (despite requests that it do so) demonstrated an intent to ratify the ICC's construction of those provisions would be "the product of a set of inferences none of which is free from doubt." Id.

and as has been clearly shown in petitioner's brief, at pages 84-92. Particularly inapt is the 1970 incident, which respondents mistakenly describe as an effort to secure coverage for the mentally ill in ICFs (Resp. Br. 31) but which was in fact an effort to resist a new provision that would have precluded any Medicaid for residents of public ICFs for the mentally retarded. See Pet. Br. 88-89. This is clearly shown in the hearing record at the pages cited by respondents and the exhibit referred to in the testimony on those pages. Social Security Amendments of 1970: Hearings Before the Senate Comm. on Finance on H.R. 17550, 91st Cong., 2d Sess. 502-506, 520 (1970).

C. The Unaltered Department Regulations

Petitioner showed that the current Departmental interpretation of the IMD clause is contrary to the interpretation

adopted at the time Medicaid was first enacted and maintained thereafter for many years. Pet. Br. 72-78. Respondents implicitly recognize the correctness of this showing, which was based in part on the regulation adopted immediately after the Act was passed defining an IMD eligible to participate with respect to persons aged 65 and over solely in terms of a mental hospital. But respondents attempt to dismiss the significance of this action by saying that as SNFs and ICFs specializing in the care of the mentally ill "became increasingly common," that limiting regulation was dropped. Resp. Br. 43.

Respondents have apparently been misled by the rearrangement of the Department's regulations over the past decade. The original regulation has not been dropped. It remains in effect and is

contained in 42 C.F.R. § 440.140(a)(1)(ii).¹⁵ Thus, the point previously made remains -- under the view now espoused by respondents, persons over 65 could not receive medical assistance in ICFs and SNFs specializing in their care, because those facilities would not meet the IMD standard of 42 C.F.R. § 440.140(a)(1)(ii). Thus would the respondents' approach achieve the ultimate reversal of the policy objectives of the Long Amendment.¹⁶

¹⁵ The regulation requires that a qualifying IMD meet the standards of 42 C.F.R. §§ 405.1035 and 405.1036. These sections, particularly § 405.1036 (and sections 405.1037 and 405.1038 which it incorporates by reference) set forth the standards that must be met for a facility to qualify as a psychiatric hospital under the Medicare program.

¹⁶ Respondents' brief fails to cite or mention the 1971 Department report to Congress describing nursing home services for the mentally ill as among those available for which Medicaid support is available (see Pet. Br. 75-77 and App. C) -- still further evidence of the contemporaneous understanding within the Department that the IMD provision was confined to mental hospitals.

D. Community Mental Health
Center Legislation

Respondents try to advance the Community Mental Health Center (CMHC) legislation as the Congressional substitute for care of the mentally ill between ages 21 and 64. Resp. Br. 39-41. This effort does not avail. The CMHC program's primary purpose was to grant funds for construction of mental health centers (although for some years funds for staffing and operations were also provided). No means testing is involved, and there is no reimbursement for the cost of patient care. Contrary to respondents' assertion (Resp. Br. 41), when Congress cut back on the funding of CMHCs, it affected all users, not just those aged 21 to 64. The CMHC legislation provides no support for respondents' interpretation of the IMD provision of the Medicaid law.

IV. THE PROPRIETY OF THE
"PENNHURST" ARGUMENT

Lastly, respondents assert that the argument in Section III of petitioner's brief cannot be considered because it seeks to raise a ground for reversal not encompassed within the "Question Presented" in the Petition for Writ of Certiorari. Resp. Br. 48. We think this mischaracterizes the argument.¹⁷ Petitioner does not challenge the power of Congress to adopt an explicit IMD provision that fits respondents' interpretation. But Congress has not done so. Rather, DHHS adopted an approach that made it difficult if not impossible for a state to know until after the fact whether a facility would be covered by the IMD

¹⁷ Petitioner's summary of the argument may well have led respondents to make this point. See Pet. Br. 19-21.

exception.¹⁸ Because this approach is so inconsistent with the principles underlying the Pennhurst decision, it ought not be attributed to Congress in the absence of the most compelling evidence. This is the essence of the argument in Section III. It is supported by the well-accepted maxim that statutes are construed where possible to avoid potentially serious constitutional issues. See Califano v. Yamaski, 442 U.S. 682, 692-93 (1979); St. Martin Evangelical Lutheran Church v. South Dakota, 451 U.S. 772, 780 (1981).

¹⁸ Respondents seek to avoid this conclusion by relying on Connecticut's awareness in 1976 that an issue had been raised about extending the IMD clause to SNFs and ICFs. See Pet. Br. 95, n.74; Resp. Br. 49. But knowing that the issue was presented was not equivalent to knowing how it would be resolved or how DHHS might apply its new policy. As shown previously (Pet. Br. 94-102), Connecticut could not reasonably have known the outcome of the audit of Middletown Haven until the result was announced.

As such, Section III is directly related to the "Question Presented" and is properly before the Court.

CONCLUSION

For the foregoing reasons and those set forth in petitioner's opening brief, the judgment of the court of appeals should be reversed.

Respectfully submitted,

CHARLES A. MILLER*
MICHAEL A. ROTH
ROBIN J. ARMBRUSTER
Covington & Burling
1201 Pennsylvania Avenue, N.W.
P.O. Box 7566
Washington, D.C. 20044
(202) 662-6000

JOSEPH I. LIEBERMAN
Attorney General
30 Trinity Street
Hartford, Connecticut 06106

DONALD M. LONGLEY
Assistant Attorney General
90 Brainard Road
Hartford, Connecticut 06114

Attorneys for Petitioner State
of Connecticut, Department of
Income Maintenance

March 1985

*Counsel of Record